

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



STATE OF NEBRASKA  
MIKE JOHANN, GOVERNOR

August 28, 2003

Ms. LouEllen M. Rice, Grants Management Officer  
SAMHSA Office of Program Services  
Division of Grants Management  
Room 13-103 Parklawn Building  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Rice

Enclosed please find an original and two copies of the Nebraska State Plan for Comprehensive Community Mental Health Services for the Fiscal Year 2004. This is a one year plan, covering Sections I, II, and III. Nebraska's "Implementation Report for FY2003" will be submitted by December 1, 2003.

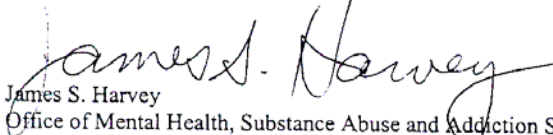
The State of Nebraska fiscal year is July 1 to June 30. All information reported within this application is based on that time frame unless otherwise noted.

The official identified by Governor Johann as responsible for administration of CMHS Block Grant continues to be Ron Ross, Director, Nebraska Department of Health and Human Services.

Ron Ross has designated Ronald E. Sorensen, Administrator, Office of Mental Health, Substance Abuse and Addiction Services to receive the NOTICE OF BLOCK GRANT AWARD concerning the Community Mental Health Block Grant.

If you have questions do contact me. Thank you for your review of this application.

Sincerely,

  
James S. Harvey  
Office of Mental Health, Substance Abuse and Addiction Services  
Nebraska Department of Health and Human Services

Cc: Richard DiGeronimo, State Planning and Systems Development Branch  
Center for Mental Health Services, U.S. Department of Health and Human Services

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Nebraska FY2004 Community Mental Health Services Block Grant Application \* page 1

**APPLICATION FACE SHEET FOR FY 2003  
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT  
(Circle all that apply)**

STATE NAME: Nebraska

**I. AGENCY TO RECEIVE THE CMHS BLOCK GRANT**

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Office of Mental Health, Substance Abuse and Addiction Services

STREET ADDRESS: PO Box 98925

CITY: Lincoln ZIP CODE: 68509-8925

TELEPHONE: (402) 479-5125 FAX: (402) 479-5162

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR  
ADMINISTRATION OF CMHS BLOCK GRANT**

NAME & TITLE: Ron Ross, Director

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: \_\_\_\_\_

STREET ADDRESS: P.O. Box 95044

CITY: Lincoln ZIP CODE: 68509- 5044

TELEPHONE: (402) 471-9106 FAX: (402) 471-0820

**III. STATE FISCAL YEAR**

FROM: July 1 TO: June 30

**IV. PERSON TO CONTACT WITH ANY QUESTIONS REGARDING THE  
APPLICATION**

NAME & TITLE: James S. Harvey, LCSW; Quality Improvement Coordinator

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Office of Mental Health, Substance Abuse and Addiction Services

STREET ADDRESS: PO Box 98925

CITY: Lincoln ZIP CODE: 68509-8925

TELEPHONE: (402) 479-5125 FAX: (402) 479-5162 EMAIL: jim.harvey@hhss.state.ne.us

## TABLE OF CONTENTS

Overview	
Cover Letter .....	1
Application Face Sheet For FY 2004.....	2
Table of Contents .....	3
Executive Summary .....	4
Letter from Governor for Designation.....	5
Letter from Director Regarding Notice of Grant Award .....	6
Section I - Application Information	
Funding Agreements, Certifications, Assurances .....	7
Maintenance of Effort .....	11
Set-Aside for Children's Mental Health Services .....	11
State Mental Health Planning Council Membership Requirements .....	12
NOTE: Letter from Chair MHPEC (at end of application)	
Section II - State Plan Context	
Overview of the Nebraska Behavioral Health System	
D. Legislative initiatives .....	21
E. Description of regional programs within the State.....	23
F. Description of State leadership .....	25
H. Critical gaps and unmet needs - and -	
I. Source of data used to project critical service gaps.....	28
Section III – Fiscal Planning Assumptions Adults and Children .....	40
Section III – ADULT PLAN.....	45
Section II - Adult State Plan Context	
Adult Goals	
A. State service system as envisioned for the future;	
B. Previous State plan;	
C. New developments and issues;	
Section III - Adult State Plan	
Adult State Plan (Four Criteria) .....	55
Section III – CHILDREN PLAN.....	81
Section II - Children State Plan Context	
Children Goals	
A. State service system as envisioned for the future;	
B. Previous State plan;	
C. New developments and issues;	
Section III - Children State Plan	
Child State Plan (Five Criteria) .....	91

NOTE: LETTER FROM THE CHAIR OF MHPEC ATTACHED – LAST PAGES

## **EXECUTIVE SUMMARY**

### **Nebraska FY2004 Community Mental Health Services Block Grant Application**

The Nebraska Department of Health and Human Services (HHS) is the State Mental Health Authority. HHS Office of Mental Health, Substance Abuse and Addiction Services addresses the non-Medicaid public behavioral health services through contracts with the six Regional Governing Boards to purchase community mental health services. A conservative estimate, in general, in the contracts to purchase community mental health, 93% are State funds and 7% are federal community mental health block grant.

The Legislature needed to make massive cuts to the State of Nebraska budget. With that stated, drought does continue to impact Nebraska's economy. As of August 2003 all of the state is listed in some level of drought. As an agricultural state, that's a problem. However, the state aid for FY2004 community mental health remained the same as previous fiscal year.

On May 13, 2003, the "Nebraska Behavioral Health Reform Act" (LB724) was approved by the Governor. The purpose of the Act is to state legislative intent for reform of the behavioral health system and for a substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska. On August 20, 2003, the LB 724 Draft "Outline of Implementing Legislation for Behavioral Health System Reform" was released by Governor Johanns and Senator Jensen (Chair, Health and Human Services Committee, Nebraska Legislature). Included in that document was a proposal to close one or more regional centers within the next two years.

The Statewide Mental Health Housing Coalition was formed between the Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse and Addiction Services and the Nebraska Department of Economic Development (DED) Community and Rural Development Division. Both HHS and DED are committed to the development of housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness.

With all of this in mind, here are the goals for FY2004.

#### **FY2004 GOALS FOR ADULTS**

- Goal #1: Strategic Planning
- Goal #2: Continue To Improve Quality, Delivery Of Services And Consumer Access
- Goal #3: Empower Consumers
- Goal #4: Suicide Prevention Initiative

#### **FY2003 GOALS FOR CHILDREN OR ADOLESCENTS**

- Goal #1: Strategic Planning
- Goal 2: Family Support
- Goal #3: Integration of Service Systems

# STATE OF NEBRASKA

OFFICE OF THE GOVERNOR  
P.O. Box 94848  
Lincoln, Nebraska 68509-4848  
Phone: (402) 471-2244

August 20, 2003



Mike Johanns  
Governor

Ms. Lou Ellen M. Rice  
Grants Management Officer  
Office of Program Services, Division of Grants Management  
Substance Abuse and mental Health Services Administration  
Rockwall II, Suite 630  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Rice:

On behalf of the State of Nebraska, I hereby authorize the Director of the Department of Health and Human Services to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant.

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Community Mental Health Block Grant to:

Ron Ross, Director  
Department of Health and Human Services  
PO Box 95044  
Lincoln, NE 68509-5044

Thank you for your attention to this matter

Sincerely,

A handwritten signature of Mike Johanns in black ink.

Mike Johanns, Governor

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



STATE OF NEBRASKA  
MIKE JOHANNIS, GOVERNOR

August 20, 2002

Ms. Lou Ellen M. Rice  
Grants Management Officer  
Office of Program Services, Division of Grants Management  
Substance Abuse and mental Health Services Administration  
Rockwall II, Suite 630  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Rice:

Effective immediately and until further notice, please send the NOTICE OF BLOCK GRANT AWARD concerning the Community Mental Health Block Grant to:

Ronald E. Sorensen, Administrator  
Office of Mental Health, Substance Abuse and Addiction Services  
Nebraska Department of Health and Human Services  
P.O. Box 98925  
Lincoln, NE 68509-8925

Thank you for your attention to this matter

Sincerely,



Ron Ross, Director  
Nebraska Department of Health and Human Services

Cc: Richard DiGeronimo, State Planning and Systems Development Branch  
Center for Mental Health Services  
U.S. Department of Health and Human Services

## **FUNDING AGREEMENTS AND CERTIFICATIONS**

Community Mental Health Services Block Grant Funding Agreements  
Fiscal Year 2004 (Attachment A)

Pages 7a, 7b, 7c, 7d, 7e

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING  
AGREEMENTS

FISCAL YEAR 2004

I hereby certify that Nebraska agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

**Section 1911:**

Subject to Section 1916, the State<sup>1</sup> will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

**Section 1912**

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

**Section 1913:**

(a)(1)(C) In the case for a grant for fiscal year 2004, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psycho social rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

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<sup>1</sup>The term State shall hereafter be understood to include Territories.

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner, which preserves human dignity and assures continuity and high quality care.

**Section 1914:**

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are—

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of—

- (A) the principle State agencies with respect to—
  - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
  - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that—

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
- (B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

**Section 1915:**

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912 (a) with respect to the grant and the report of the State under section 1942 (a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912 (a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942 (a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

**Section 1916:**

(a) The State agrees that it will not expend the grant—

- (1) to provide inpatient services;
- (2) to make cash payments to intended recipients of health services;
- (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

- (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
- (5) to provide financial assistance to any entity other than a public or nonprofit entity.
- (b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

**Section 1941:**

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

**Section 1942:**


- (a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of--
  - (1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
  - (2) the recipients of amounts provided in the grant.
- (b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]
- (c) The State will--
  - (1) make copies of the reports and audits described in this section available for public inspection within the State; and
  - (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

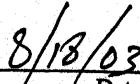
**Section 1943:**

- (a) The State will--
  - (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
  - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
  - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
  - (3) provide to the Secretary any data required by the Secretary pursuant to section

505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

  
\_\_\_\_\_  
Governor  
DIRECTOR - HHS

  
\_\_\_\_\_  
Date

Certifications (OMB Approval 0348-0040) (Attachment B)

- a. Debarment and Suspension
- b. Drug-Free Workplace Requirements
- c. Lobbying and Disclosure
- d. Program Fraud Civil Remedies Act (PFCRA)
- e. Environmental Tobacco Smoke

Pages 8a, 8b, 8c

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management  
Office of the Assistant Secretary for Management and Budget  
Department of Health and Human Services  
200 Independence Avenue, S.W., Room 517-D  
Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

##### 5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

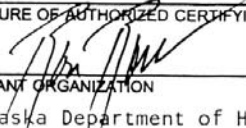
Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

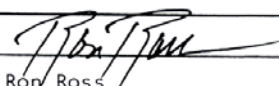
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE Director
APPLICANT ORGANIZATION Nebraska Department of Health and Human Services	DATE SUBMITTED 8/18/03



# DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b> <input checked="" type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance		<b>2. Status of Federal Action</b> <input checked="" type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award		<b>3. Report Type:</b> <input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change <b>For Material Change Only:</b> Year _____ Quarter _____ date of last report _____	
<b>4. Name and Address of Reporting Entity:</b>  Prime <input checked="" type="checkbox"/> Subawardee Tier _____, if known:  Congressional District, if known:			<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b> State of Nebraska Department of Health & Human Services P.O Box 95044 Lincoln, NE 68509-5044  Congressional District, if known:		
<b>6. Federal Department/Agency:</b>  SAMHSA Center for Mental Health Services			<b>7. Federal Program Name/Description:</b>  Community Mental Health Services Block Grant  CFDA Number, if applicable:		
<b>8. Federal Action Number, if known:</b>			<b>9. Award Amount, if known:</b> \$ 2,099,881.00		
<b>10. a. Name and Address of Lobbying Entity</b> (if individual, last name, first name, MI):			<b>b. Individuals Performing Services</b> (including address if different from No. 10a.) (last name, first name, MI):		
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>					
Signature:  Print Name: Ron Ross Title: Director Telephone No.: 402 471-9106 Date: 8/18/03			Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)		

Assurances – Non-Construction Programs (OMB Approval 0348-0040) (Attachment C)

Page 10a, 10b

**ASSURANCES - NON-CONSTRUCTION PROGRAMS**

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

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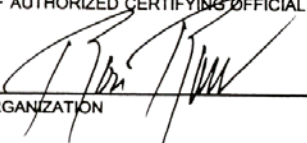
**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

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Prescribed by OMB Circular A-102

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 		TITLE  Director
APPLICANT ORGANIZATION  Nebraska Department of Health and Human Services		DATE SUBMITTED  8/18/03

SF-424B (Rev. 7-97) Back

## Section I APPLICATION INFORMATION

### 4. Maintenance of Effort (MOE)

Section 1915(b)(1) of the PHS Act (42 U.S.C. 300x-4) requires that States submit information sufficient to enable the Secretary to make a determination of compliance with the statutory MOE requirements. Specifically, MOE information is required to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant. Section 1915(b)(2) provides that the Secretary may exclude from the aggregate State expenditures under subsection (a), funds appropriated to the principle agency for authorized activities which are of a non-recurring nature and for a specific purpose. Please provide the following information:

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Mental Health Services		
Actual 2002	Actual 2003	Actual/Estimated 2004
<b>\$24,015,746</b>	<b>\$29,036,852</b>	<b>\$29,874,816</b>

**\*NOTE:** Local contractors have the flexibility to contract per the local priorities and needs in adult and children's services; therefore, the amount of funds contacted may fluctuate between adults and children's services annually.

### 5. Set-Aside for Children's Mental Health Services

Section 1913(a) of the PHS Act (42 USC 300x-3) requires that the State provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for Fiscal Year 1994.

Please provide the following information:

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Children's Services			
Calculated 1994	Actual 2002	Actual / 2003 *	Actual/Estimated 2004
<b>\$620,801</b>	<b>\$3,793,391</b>	<b>\$3,872,010</b>	<b>\$3,820,804</b>

**\*NOTE:** (1) An additional \$1,500,000 was expended from a CMHS special children's grant. FY03 was the final year of the grant, but some carryover funds remain; therefore, it is not included in the base actual or estimated expenditures. (2) Local contractors have the flexibility to contract per the local priorities and needs in adult and children's services; therefore, the amount of funds contacted may fluctuate between adults and children's services annually. (3) Revised billings were approved for June, 2003 in August, 2003, therefore, the actual for FY03 will change when the payments have cleared the system.

## **Section I APPLICATION INFORMATION**

### **Mental Health Planning and Evaluation Council (MHPEC)**

6. State Mental Health Planning Council Membership Requirements
7. Planning Council Charge
8. State Mental Health Planning Council Comments and Recommendations (Section 1915 (a))
9. State Mental Health Planning Council Membership List (Table 1)
10. List of Planning Council Members (Table 1)
11. Planning Council Composition by Type of Member (Table 1A)

### **MHPEC MEMBERSHIP REQUIREMENTS:**

Membership of the Nebraska Mental Health Planning and Evaluation Council is based on the categories prescribed by the state and federal law. Nebraska Statute states the council shall consist of not more than thirty-four members [§71-5008. (2)] (see statute listed below)

### **MHPEC PLANNING COUNCIL CHARGE**

In Nebraska, the charge to the Mental Health Planning and Evaluation Council includes (1) the Federal requirements, (2) Nebraska State Statute, and (3) MHPEC By-laws. Below are the Nebraska State Statute and current MHPEC By-Laws.

**Nebraska State Statute:** §71-5008. State Mental Health Planning and Evaluation Council; created; duties; members; appointment; meetings; expenses.

- (1) The State Mental Health Planning and Evaluation Council is hereby created. The council shall:
  - (a) Identify program needs and offer guidance to the department on program priorities for the state;
  - (b) Provide objective input, feedback, and comment on state plans proposed by the department;
  - (c) Act as an advocate for the interests of consumers and their families;
  - (d) Monitor the implementation of the state plans and provide evaluation of those plans;
  - (e) Offer to the executive and legislative branches of state government any proposals or recommendations that the council deems appropriate. The council shall report its findings and recommendations to the Governor and the Legislature by October 1 of each year;
  - (f) Serve as the state's mental health planning council as required by Public Law 102-321; and
  - (g) Examine and make recommendations in regard to policies and practices for meaningful consumer participation in the treatment planning process.
- (2) The council shall consist of not more than thirty-four members appointed by the Governor as follows:
  - (a) One member of a regional governing board established pursuant to section 71-5004;
  - (b) Not less than fourteen consumers and family members, with no more than four from any one region. The consumer representatives and the family representatives shall be as nearly as possible equal in number;
  - (c) One regional program administrator;
  - (d) Six service providers, with no more than one from each region and no more than two representing any one particular discipline;
  - (e) One representative from the Division of Vocational Rehabilitation of the State Department of Education;
  - (f) One representative from the Department of Health and Human Services Finance and Support;
  - (g) One representative from the Department of Health and Human Services;
  - (h) One representative from the Nebraska Commission on Law Enforcement and Criminal Justice;

- (i) One representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development;
  - (j) One representative from the State Department of Education other than the member appointed under subdivision (e) of this subsection; and
  - (k) Other members as appointed by the Governor.
- The respective constituencies listed in subdivisions (a) through (d) of this subsection shall submit lists of nominees to the Governor for his or her consideration in making the appointments required by such subdivisions. The Commissioner of Education, the Director of Finance and Support, the Director of Health and Human Services, the executive director of the commission, and the Director of Economic Development shall submit lists of nominees to the Governor for his or her consideration in making the appointments required by subdivisions (e) through (j), respectively, of this subsection.
- (3) The initial members of the council shall be appointed for staggered terms of three years, as determined by the Governor. As the terms of the initial members expire, their successors shall be appointed for terms of three years. The council shall elect a chairperson from the members of such council.
  - (4) The council shall meet on a quarterly basis. Upon receiving the written approval of the Director of Health and Human Services, the chairperson may appoint and utilize a task force of council members and nonmembers to report to the council on specific areas.
  - (5) Members of the council shall be reimbursed for actual and necessary expenses as provided in sections 81-1174 to 81-1177.

**MHPEC By-Laws** (as of February 4, 2002)

**SECTION 1 – NAME**

The name of this public body shall be the Nebraska Mental Health Planning and Evaluation Council, here after referred to as MHPEC.

**SECTION 2 – PURPOSE**

The purpose of the MHPEC is to advise the executive and legislative branches of state government and to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems consistent with Federal and State requirements (see attachments on state statute §71-5008 and Federal requirements under the Community Mental Health Services Block Grant Agreement, Section 1914).

**SECTION 3 – MEMBERSHIP**

3.01 – CRITERIA - The membership of the MHPEC will be consistent with the requirements of the State and Federal requirements (see attachments).

3.02 – VOTING - The Council members may require an official vote as determined by the members on any question before the Council. Each member will have one vote.

3.03 – ATTENDANCE - Members shall make very effort to attend all Nebraska Mental Health Planning and Evaluation Council meetings. The Council shall meet four (4) times during a calendar year. When a member fails to attend two (2) meetings in person during a 12 month period, the Nebraska Mental Health Planning and Evaluation Council Executive Committee may offer recommendations to the Governor regarding continued service or replacement of members. The Governor makes the final determination.

## SECTION 4 – OFFICERS

4.01 – OFFICERS - The council shall elect a chairperson and two Vice-Chairs from the members of the council.

4.02 – COUNCIL CHAIRPERSON - the Council shall elect the Chairperson of the Nebraska Mental Health Planning and Evaluation Council at the last meeting of the State fiscal year. The Chairperson shall preside over Council meetings and serve as a liaison to the Governor and the Legislature and perform other related duties.

4.03 – COUNCIL VICE CHAIRPERSONS - The Nebraska Mental Health Planning and Evaluation Council shall elect two Vice-Chairs from its membership at the last meeting of the fiscal year.

4.04 – EXECUTIVE COMMITTEE - The Chairperson, the two Vice-Chairs and three Members-At-Large shall constitute the Executive Committee of the Nebraska Mental Health Planning and Evaluation Council. The three at-large members of the Executive Committee shall be elected from the members of the Council at the last meeting of the fiscal year. The MHPEC Executive Committee is authorized to represent MHPEC between quarterly meetings. The MHPEC Executive Committee will be composed of the same configuration as the MHPEC as a whole, which is at least 50% consumer / family.

## SECTION 5 – QUORUM

Fifteen members of the Council present shall constitute a quorum sufficient to conduct its business and take action.

## SECTION 6 – COMMITTEES

6.01 – Per Nebraska Rev. Stat. section 71-5008(4), upon receiving the written approval of the Director, the chairperson may appoint and utilize a “Task Force” of council members and nonmembers to report to the council on specific areas.

6.02 – A sub-committee, or other forms of a working group of the Council, appointed by the MHPEC Executive Committee, to carry out the specific duties of the Council specified in the state and/or federal requirements, is not considered a “Task Force”.

## SECTION 7 – FINANCIAL SUPPORT

The Nebraska Department of Health and Human Services will provide the necessary financial support for the Council as provided in Sections 81-1174 to 81-1777.

## SECTION 8 – CHANGES IN BYLAWS

Amendments to bylaws will be addressed as needed. Following a discussion of proposed changes, members will be given advance notice of the proposed changes to the Council bylaws for consideration and/or adoption at the meeting. Changes to bylaws require a two-thirds (2/3) vote of those members present.

## SECTION 9 – STAFFING

The HHS Deputy Director shall designate staff to be responsible for working with the Executive Committee, planning meetings, maintaining records, logistical support, and various other liaison activities.

## SECTION 10 – ATTENDANCE BY PUBLIC

Per the open meeting laws (sections 84-1408 to 84-1414), every meeting of the MHPEC shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies. The Chair shall be responsible for indicating the appropriate time for public comment on the agenda.

## SECTION 11 – EFFECTIVE DATE OF THE MHPEC BY - LAWS

- These bylaws were first adopted on March 14, 1995.
- The members of the MHPEC made revisions to these By-Laws:
  - Proposed changes were reviewed on June 20, 2000 and August 8, 2000.
  - Approved January 18, 2001
- Amendments to the Bylaws (section 4.04)
  - Proposed changes were introduced on August 16, 2001.
  - Proposed amendment discussed November 13, 2001 meeting
  - Approved the amendment during February 4, 2002 meeting.

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Current MHPEC Officers are

Constance Zimmer .....Chairperson  
Cynthia Scott.....Vice-Chair  
Donald E. Fischer .....Vice-Chair  
Judy Morris .....Members-At-Large  
Margaret Baker .....Members-At-Large  
Thomas Bockes .....Members-At-Large

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## State Mental Health Planning Council Membership List (Table 1)

As of August 22, 2003

	NAME	TYPE OF MEMBERSHIP	AGENCY OR ORGANIZATION	ADDRESS, PHONE & FAX
Consumers				
1	Darlene Richards	Adult with Serious Mental Illness	Consumer / Region 1	310 w. 5TH, Apt 3 Bridgeport, NE 69336 308 262-2950
2	Jimmy Burke	Adult with Serious Mental Illness	Consumer / Region 5	4603 Prescott Ave Lincoln, NE 68506 402 483-4086
3	John Chester	Adult with Serious Mental Illness	Consumer / Region 6	5706 S. 96 Court, Apt. 56 Omaha, NE 68127 402-331-6446
4	Michael Oliverius	Adult with Serious Mental Illness	Consumer / Region 5	1944 Prospect, #1 Lincoln, NE 68502 402 477-2248
5	Monte Hayes	Adult with Serious Mental Illness	Consumer / Region 4	3717 27th Street, Apt 31 Columbus, NE 68601 402 564-9724
6	Richard Ellis	Adult with Serious Mental Illness	Consumer / Region 5	4123 Pace Blvd Lincoln, NE 68502 402 420-7415

7	Wayne Adamson	Adult with Serious Mental Illness	Consumer / Region 3	1363 West E, #4 Hastings, NE 68901 402 463-0532
8	Wesley Legan	Adult with Serious Mental Illness	Consumer / Region 6	3326 N. 162 <sup>nd</sup> Court, Apt. 205 Omaha, NE 68816 402-933-3262
Family Members of Children with SED				
9	Constance Zimmer	Family Members of Children with SED	Family Child w/ SED / Region 5	3350 M Street Lincoln, NE 68510 402 435-0301
10	Cynthia Scott	Family Members of Children with SED	Family Child w/ SED / Region 3	PO Box 25 Juniata, NE 68955 402 751-2226
11	Clint Hawkins	Family Member of Child with SED	Family Child w/ SED / Region 4	P.O. Box 722 Woodlake, NE 69221 402-967-3012
Family Members of Adults with SMI				
12	Judy Morris	Family Members of Adults with SMI	Family Adult w/ SMI / Region 2	231 E 18th - RR 2, Box 125 Imperial, NE 69033 308 882-4592
13	Mary Wells	Family Members of Adults with SMI	Family Adult w/ SMI / Region 3	HC 71, Box 114-A Anselmo, NE 68813 308 382-675
14	Nancy Kratky	Family Members of Adults with SMI	Family Adult w/ SMI / Region 6	1204 N 101 Circle Omaha, NE 68114 402 390-0956
15	Thomas Bockes	Family Members of Adults with SMI	Family Adult w/ SMI / Region 6	2618 no. 56th Omaha, NE 68132 402 558-9417
16	Mary T. Jackson	Family Members of Adults with SMI	Family Adult w/ SMI / Region 6	PO Box 34604 Omaha, NE 68134 402 397-0737
Other Representatives				
17	Ann Masters	State Education Agency	Dept. of Education	PO Box 94987 Lincoln, NE 68509 402 471-4816
18	Dan Sturgis	Other / State Psychiatric Hospitals	Norfolk Regional Center	1507 Skyline Drive Norfolk, NE 68701 402 379-0522
19	Donald E. Fischer, MD	Service Provider	Private Practice Psychiatrist	3401 16th Ave Scottsbluff, NE 69361 308 632-3141
20	Frank Lloyd	State Vocational Rehabilitation	Dept. of Education, Vocational Rehabilitation Services	4409 Browning Pl Lincoln, NE 68516 402 420-2202
21	George Hanigan	HHS Rep. (State mental health & social services)	Deputy Director, Dept. Health & Human Services	RR 1, Box 36 Hallam, NE 68368 402 794-4155

22	James Deaver	Regional Governing Board	Region 2 Governing Board	Route 2, Box 72 Imperial, NE 69033 308 352-4000
23	Kris Nolan Brown	Service Provider	Goodwill Industries of Greater Nebraska, Inc	1720 S. Curtis Grand Island, NE 68803 308 384-6327
24	Lara J. Huskey	State Housing Agency	Dept of Economic Dev / Comm & Rural Dev Division;	3920 LaSalle Lincoln, NE 68516 402 489-7315
25	Susan Boust	Service Provider	University of Nebr Medical Center, Dept. of Psychiatry	Dept. of Psychiatry 985578 Nebraska Medical Center Omaha, NE 68198-5578
26	Margaret Baker	Service Provider	Great Plains Regional Medical Center North Platte	1011 Locust Sutherland, NE 69159 308 386-2287
27	Marylyde Kornfeld	Service Provider	Adams Street Center, Comm M H Ctr Lancaster Cty	3314 So. 40th Street Lincoln, NE 68506 402 488-3372
28	Eli McBride	Crime Commission (State Criminal Justice)	Juvenile Justice Compliance Monitor - NE Crime Commission	PO Box 94646 Lincoln, NE 68509 402 471-3998
29	Roxie Cillessen	State Medicaid (Title XIX)	Children's BH Coord. HHS / Finance & Support	RR 2, Box 43B Martell, NE 68404 402-794-8315
30	Rudi L Mitchell	Service Provider	Carl T. Curtis Ed. Center, Omaha Tribe of NE/IA	RR 1, Box 21 Macy, NE 68039 402 837-5034
31	Jean Sturtevant	Regional Program Administrator	Region 4 Program Administrator	Region 4 Mental Health & Substance Abuse Admin. 206 Monroe Avenue Norfolk, NE 68701 402-370-3100

11. Planning Council Composition by Type of Member (Table 1A)

Type of Council Members	Total Members
Consumers	8
Family Members of Children with SED	3
Family Members of Adults with SMI	5
Other Representatives	15
Vacancies	
Individuals other than State employees and providers of mental health services	16 (50%)
Individuals who are state employees and providers of mental health services	15 (50%)

## **Section II – State Plan Context**

### **G. The role of the State Mental Health Planning Council in improving mental health services within the State**

The State Mental Health Planning Council's role starts with Neb. Rev. Stat. §71-5008(1) which describes what the "State Mental Health Planning and Evaluation Council" is authorized to do. Please see the section **Nebraska State Statute** §71-5008. (1)(a)-(g) above. According to Neb. Rev. Stat. §71-5008(4), the council is authorized to meet on a quarterly basis. Here is the schedule for calendar years 2002 and 2003

<b>2002 Schedule</b>		
1st Quarter (Jan - Mar):	February 4, 2002	by Video Conference
April 12, 2002 – MHPEC Strategic Planning Meeting in Lincoln, NE		
2nd Quarter (Apr-Jun):	June 14, 2002	by Video Conference
3rd Quarter (Jul-Sept):	August 15, 2002	in Lincoln
4th Quarter (Oct-Dec):	November 13, 2002	in Lincoln
November 12, 2002 (2:00 p.m. to 5:00 p.m.) is scheduled for new member orientation		
<b>2003 Schedule</b>		
1st Quarter (Jan - Mar):	February 21, 2003	in Lincoln
2nd Quarter (Apr-Jun):	June 12, 2003	in Lincoln
3rd Quarter (Jul-Sept):	August 8, 2003	in Lincoln
4th Quarter (Oct-Dec):	November 18, 2003	in Lincoln
November 17, 2003 (2:00 p.m. to 5:00 p.m.) is scheduled for new member orientation		

The Fall 2003 meeting will be held in conjunction with the Nebraska Mental Health Housing Summit on November 19, 2003.

The role of the State Mental Health Planning Council in improving mental health services includes its work on development of coalitions to promote community-based care for persons with serious mental illness, including transitioning young adults under Adult Goal #2: Continue To Improve Consumer Access (Housing Coalition and Employment 2003).

## **State Mental Health Planning Council Comments and Recommendations / Section 1915 (a)**

Nebraska Mental Health Planning & Evaluation Council (MHPEC) Summer 2003 meeting was held on August 8, 2003 at the Lancaster County Extension Education Center in Lincoln, NE. There were 14 MHPEC members present at start of the meeting plus visitors. Below were comments received on the draft plan, **"FY2004 Community Mental Health Block Grant Application"**.

### **COMMENTS RECEIVED:**

Below represents both comments from the MHPEC Members present as well as public comments. The public comments are included because the meetings of the Mental Health Planning and Evaluation Council are open to attendance by members of the public.

Ansan Naseem, MD, FROM VA HOSPITAL / ALSO WITH THE BRYANLGH ER:

Consumers keep returning to the Emergency program because that is their only point of contact with the system. They have no insurance. They have no other options. As a result, they keep coming back to the emergency room. Need to have the capacity to document not only the substance abuse issue but also the other mental disorders present.. We have sick patients ... some sicker than others ... it becomes a dangerous situation ...

CJ Zimmer (MHPEC member) noted that with the Housing Study, MHPEC was involved from the beginning. Input on the RFP, review of the proposals and selection of bids, serve on the MH Housing Steering committee ...

Gap #1: Discrepancy in Prevalence and # served / Children:

On August 8, 2003, MHPEC noted that a large number of children who still need services are not receiving them. One might theorize that some populations of children may be "over-served" while others remain unserved because they are outside the eligibility boundaries of child serving systems with adequate funding for mental health care.

As a result, because of the inadequate data systems, the real need is still unknown.

Gap #2:

MHPEC noted that developmentally appropriate services for youth in transition, including youth who have Developmental Disabilities with mental illness, poor services coordination; diagnosis shopping to ensure DD diagnosis is primary to ensure service provision and related activities in order to receive services.

Gap #3: Need to clarify what are post commitment days.

**GAP #5: SHORTAGE OF CREDENTIAL & ADMINISTRATIVE STAFF**

Donald E. Fischer, MD, DABFM, C.A.S.A.M (MHPEC member) commented on the lack of expertise available to work with persons with dual disorders.

Gap #7: Culturally Competent Services- add refugee population in Lincoln

Gap #8: Elderly population not being served...

### FY2003 ADULT GOAL #3: EMPOWER CONSUMERS

- Marylyde Kornfeld (MHPEC member) said Consumer Satisfaction Program Visits are good.
- Margart Baker said (MHPEC member) the "Liaison to the Mental Health Association" project is something we need.
- Community Support workers should tell consumers how to contact the HHS Consumer Liaisons Dan Powers and Phyllis McCaul (call 1-800-836-7660 or e-mail).

Nancy Krachey, (MHPEC member)

- Fragmentation between provider groups ... groups do not know what each other does, resources they have, etc. They need to have methods to coordinate resources.
- Awareness of the system...need to distribute information regarding the system.

### Child Goal #1 - Child Strategic Planning ...

Dennis McCarriville and Mary Fraizer Meintz with Uta Hallee

- Providers of children services be involved in any strategic planning areas - non governmental providers, NABHO, etc.
- Need the data reported for the strategic planning ...
- Involve consumers, providers in strategic planning and nongovernmental folks...
- Need for data;

### Child Goal #2

- There is an inner circle and outer circle ... the inner circle group gets the funding.
- Needs to be opened up so that all family groups may be eligible for receiving these family resources.
- There are other "takes" on family organizations ... open up opportunities with other family organizations ...
- one organization per Region is a bad idea ...say at least one per Region ...
- How much money in the Families Unite Project? (page 79).
- Define what child centered and family focused really mean (criteria). Everyone says they are "family focused" and "child centered" but when you look at their practices, not family focused and child centered.
- Need more information on the HHS Family service contract. NOTE: additional information has been added to Child Goal #2: Family Support.
- Define OJS is at the beginning of the document.

### Goal #3 – Engage the educational system as part of the integration of services system ...

- Put the money together ... follow the money ...
- Children's plan : Pay lip service for family involvement; take it seriously
- Family Organizations: Inner circle and outer circle; opened up to include others; multiple organizations to fit several families...all the eggs are in one basket..open opportunities to fund more organizations...
- There are estimated to be ...# of kids....not very many families can acutally access the service...gaps in access ...Name the Federation and other family organizations that may be excluded due to lack of funding, look critically at the criteria for funding...
- How many families served by Families Unite – Office of Juvenile Services....
- Concerns re: forming one organization at least one family organization in each behavioral health – constraints ; need to reach out...
- Look at innovative to make money stretch

## **Section II – State Plan Context**

### **Overview of the Nebraska Behavioral Health System**

#### **D. Legislative initiatives**

##### **Nebraska Behavioral Health Reform Act (LB724)**

LEGISLATIVE BILL 724 was approved by the Governor on May 13, 2003. The purpose of the "Nebraska Behavioral Health Reform Act" is to state legislative intent for reform of the behavioral health system and for a substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska. The Legislature finds that:

- (1) The separate and distinct funding and administrative mechanisms of the regional centers and the county regional governance system present significant barriers to statewide coordination of the behavioral health system;
- (2) The number of inpatients at the regional centers is significantly less than the originally designed capacity of such centers and many regional center buildings are uninhabitable or require significant expenditures of state funds for maintenance and renovation;
- (3) The size and scope of the administrative bureaucracy in each behavioral health region has significantly expanded since passage of the Nebraska Comprehensive Community Mental Health Services Act and each regional governing board both provides behavioral health services and administers state and other funds for the provision of such services;
- (4) The availability of community-based behavioral health services in the State of Nebraska is inadequate to meet the need for such services; and
- (5) Many persons with behavioral health disorders are admitted for inpatient treatment when outpatient treatment would be a clinically appropriate and less restrictive treatment alternative for such persons, mental health board commitments lack uniformity statewide, and persons are frequently retained in emergency protective custody after being committed for treatment by a mental health board and prior to the commencement of such treatment.

Sections 5 to 8 of this act discuss the intent of the Legislature to revised and recodified statutes related to the:

- regional centers (section 5)
- county regional governance system (section 6)
- statewide administration and funding of the behavioral health system (Section 7)
- Nebraska Mental Health Commitment Act (Section 8).

Section 9 says the chairperson of the Health and Human Services Committee of the Legislature shall prepare and introduce legislation or amendments to legislation in the Ninety-eighth Legislature, Second Session, to implement sections 5 to 8 of this act.

Section 10 amended Section 83-1079 regarding the mental health commitment boards

#### **STATE BUDGET CUTS**

The financial resources in the Nebraska Department of Health and Human Services have been reduced significantly over the last few years. The situation is getting worse. However, the Nebraska overall goal is to at least maintain operations, seeking ways to improve services within the limited resources available to the Nebraska Behavioral Health System (NBHS) consistent with the intent of the Governor and Legislature.

As reported in the Nebraska FY2003 Community Mental Health Services Block Grant Application (page 4 and 28), there were two special sessions and one regular session of the Nebraska Legislature. The Legislature and Governor cut the state budget by \$477 million in the special session in October 2001, the 2002 regular session, and the Summer 2002 session.

On January 15, 2003, Governor Mike Johanns said in his "State of the State Address"

- "... 2002 tax receipts were truly historic – on the down side." and
- "... the Legislative Fiscal Office defines our dilemma as a \$673 million dollar difference in projected spending needs and projected revenue over the next two years. That number is conservative. Deficit requests and a potential liability arising out of the Boyd County Low-Level Radioactive Waste Site litigation balloons this number to a staggering \$850 million dollars."

Governor Johanns referred to "Boyd County Low-Level Radioactive Waste Site litigation". This litigation refers to the \$151million, plus interest that could be due to the five-state compact (Nebraska, Louisiana, Arkansas, Oklahoma and Kansas) for the money spent on building the low-level nuclear waste dump warehouse in Boyd County, Nebraska. The \$151 million is based on the ruling by U.S. District Court Judge Richard Kopf on September 30, 2002 that Nebraska state officials denied for political reasons a license to build the low-level nuclear waste dump warehouse in Boyd County.

According to media reports (Newspaper - Lincoln Journal Star: May 15, 2003; May 18, 2003; May 31, 2003; June 20, 2003; June 21, 2003; June 27, 2003; July 15, 2003; July 18, 2003; July 19, 2003; July 28, 2003; August 11, 2003; August 12, 2003)

- The state collected less money in fiscal year 2002 than in either of the two previous years, and state government faced a \$750 million budget problem over the next two years.
- Sales, income and miscellaneous taxes collected for the fiscal year 2003 were \$49.6 million below official forecasts, according to the state Department of Revenue. Receipts were off 11.1 percent in June 2003 alone.
- The annual budget for the State of Nebraska is about \$2.6 billion.
- The 2003 Legislature finalized two-year budget for \$5.4 billion.
- To address the \$750 million budget shortfall, the Legislature cut funding for more than 30 state agencies, including the University of Nebraska.
- The Legislature raised \$343 million in tax increases.
- State tax revenues are below projections for July, the first month of the 2004 fiscal year. The state's net tax revenues were \$8 million (4.5 percent) below projections for the month.
- At least 640 state full-time-equivalent positions have been eliminated in budget cuts over almost two years.
- A major part of the bill that passed eliminates Medicaid coverage for 19- and 20-year-olds who live alone and make less than \$392 a month, known as "Ribicoff" coverage. The state estimates that more than 3,100 low-income young adults statewide will lose Medicaid eligibility

A \$58 million infusion of extra federal funds and plans to use a special cash reserve fund to pay bills during the summer months will help for the next six months. But if the economy and the tax revenue situation don't improve this fall, senators will once again be looking to cut state funding. Governor Johanns expected the state would face difficult cash flow issues in fiscal year 2004.

The Omaha, Grand Island, Lexington and South Sioux City public schools are suing the state, claiming the funding formula is unfair and inadequate. The lawsuit was filed after the state legislature cut aid to public schools this spring by 3 percent and modified the formula, resulting in a loss of money to these school districts. The Nebraska Constitution says the state must provide an

equal public education for all students. However, there is also an ongoing discussion regarding the role of the state versus local control.

At the June 12, 2003 MHPEC meeting, Frank Lloyd, Director of Nebraska Vocational Rehabilitation reported that they took a 5% state general fund budget cut.

STATE COMMUNITY MENTAL HEALTH AID SAME AS LAST YEAR – The Legislature needed to make massive cuts to the State of Nebraska budget. However, the state aid for FY2004 community mental health remained the same as previous fiscal year.

#### Drought Continues to Impact the Nebraska Economy

From the Nebraska Climate Assessment Response Committee meeting on January 30, 2003:

- Virtually every statistical summary was a reminder of what happened last year and what will get worse without a major shift in weather patterns.
- State Climatologist Al Dutcher said if the rains don't come the situation last year will pale in relation to what we will face this year.
- Mark Svoboda with the National Drought Mitigation Center at the University of Nebraska-Lincoln said Nebraska last year endured the driest period since the Dust Bowl of the 1930s, and prospects for above-normal precipitation between February and April are weak at best.
- 2002 ended with the third-lowest annual precipitation on record and \$1.2 billion in economic impact on the state's agricultural sector.

As of August 24, 2003, according to media reports (Lincoln Journal Star, page C1), drought still grips Nebraska. All of the state is listed in some level of drought, ranging from abnormally dry in the northeast to extreme drought in the southwest.

#### **E. A brief description of regional/sub State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State;**

Nebraska non-Medicaid public behavioral health system includes both the state psychiatric hospitals and the community based mental health and substance abuse programs. The community mental health and substance abuse services are for the clinically and financially eligible residents of the state of Nebraska.

In order to organize the community-based system within Nebraska, the Nebraska Comprehensive Community Mental Health Services Act established regions by dividing the state into six geographic service areas. Each of the State's 93 counties are assigned to a region. The number of counties assigned to each region are as follows: Region I - 11 counties, Region II - 17 counties, Region III - 22 counties, Region IV - 22 counties, Region V - 16 counties (including Lincoln), and Region VI - 5 counties (including metropolitan Omaha). Each region is a political subdivision of local government, directed by a board composed of one county commissioner from each of the counties represented in the region. Each of these service areas has one Regional Governing Board (RGB) formed by an interlocal agreement and whose members are made up of these county commissioners. Each RGB appoints one Regional Program Administrator (RPA).

This structure is used to distribute funds and to coordinate the provision of services through contracts with the six RGB under the authority of this Act. **The Mental Health Block Grant funds are distributed through contracts with the six regional governing boards.** These RGBs, in turn, directly operate or contract with community mental health agencies for delivery of services funded by the block grant and State aid funds. Other state funds for services are contracted directly to

agencies such as Native American Services, SA Prevention Services, Consumer & Rural Mental Health Contracts, Gambling, and SA Counselor Certification.

The Regional Governing Boards (RGB) govern and supervise the operation of behavioral health services offered within each service area. The Act requires annual service plans and budgets be submitted to the Department by each region. The budgets detail expected expenditures, revenue, and anticipated levels of services capacities. Based upon this budget, an annual contract is established between the Department and each region outlining the services to be provided, and federal and state requirements on use of the funds. The RGB's then enter into contracts with public or private service agencies or individuals within their geographic areas or directly provide the behavioral health services themselves.

Each RGB appoints a Regional Program Administrator (RPA) to be the chief executive officer responsible to the Board. The RPA is responsible for coordination, program planning, financial, and contract management, receiving recommendations of local advisory committees as well as evaluation of all mental health and substance abuse services funded through the RGB.

### **ASO for MH/SA Services**

Starting in 1995, there has been a Medicaid managed care contract for mental health and a separate contract for behavioral health. Two organizations have been providing managed care services to mental health / substance abuse programs. There were two contracts that started January 1, 2000. Those managed care contractors were:

- Magellan Behavioral Health had an administrative service only (ASO) contract
- ValueOptions had the contract for the Medicaid Managed Care

Now Magellan Behavioral Health handles the Managed Care Administration Service Organization (ASO) Mental Health and Substance Abuse (MH/SA) services contract. This contract covers both Medicaid (Managed Care Program and Medical Assistance Program) and the Nebraska Behavioral Health System (NBHS). The contract covers a three year time period, and a possible three year extension. The Medicaid portion of this started July 1, 2002. This contract was converted to the ASO format. The Nebraska Behavioral Health System (NBHS) portion started January 1, 2003.

### **ASO Contract and Data Collection**

The data base used for community based behavioral health programs was moved to Magellan Behavioral Health during the first contract cycle. Community based data collection by Magellan was implemented on July 1, 1997 and community-based utilization management was initiated in December of 1997 for those services requiring authorization.

With the renewed contract starting January 2000, a set of 81 mandatory data fields was specified. The data based maintained by Magellan Behavioral Health is one of the primary sources for the data used for this document. This data collection arrangement ended December 31, 2002.

The new contract portion covering Nebraska Behavioral Health System (NBHS) started January 2003. The Magellan Behavioral Health data system revisions are scheduled for implementation in October 2003. The revised 117 data fields for the NBHS cover

- Community mental health, community substance abuse, and the gamblers assistance program
- Sections such as demographics, admission status data, children/adol (0-18), history of substance abuse, service / authorization, financial eligibility, discharge status.

## **F. Description of how the State mental health agency provides leadership in coordinating mental health services within the broader system**

In the Lincoln Journal Star (June 9, 2003), Governor Mike Johanns said, if he was forced to pick just one area he could influence during his remaining days as Governor, it would be **mental health**.

In that same article Omaha Senator Jim Jensen, Chair of the Health and Human Services Committee of the Nebraska Legislature, said he is looking for ways to provide more housing and treatment services in local communities and examine the need for three regional centers.

Both Senator Jensen and Governor Johanns were involved in "Nebraska Behavioral Health Reform Act" (**LEGISLATIVE BILL 724**). This bill was approved by the Governor on May 13, 2003. The purpose of this Act is to state legislative intent for reform of the behavioral health system and for a substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska.

Senator Jensen, as the chairperson of the Health and Human Services Committee of the Legislature, is to prepare and introduce legislation or amendments to legislation in the Ninety-eighth Legislature, Second Session (Spring 2004 session).

These are not new positions. Senator Jensen said the following on mental health issues:

"We need an incremental and long-term approach that's focused on removing current deficiencies and barriers in the system and is focused not on the system but on helping people. .... We need to ensure that basic core services are available and accessible and that they're competently and efficiently provided. And we need to focus on enabling people to help themselves and to live and work in their communities with the greatest possible independence and self-sufficiency."

(Omaha World Herald, February 1, 2001)

On April 18, 2001, Governor Mike Johanns said:

"(mental health) monies are targeted to expand community based services across the state in response to crisis situations at the local level ... (monies) Focused on five Priorities:

- Decreasing the number of post commitment days
- Decreasing the number of Emergency Protective Custody situations
- Decreasing the number of days consumers are served in inappropriate levels of care
- Decreasing the number of commitments to Regional Centers for substance abuse; and
- Increase the service capacity available to these special populations, including those who are in the juvenile justice system"

(Speech before the Region V Special Populations Conference, April 18, 2001)

### **HHSS**

The Nebraska Partnership Act (1996), effective on January 1, 1997, created the Nebraska Health and Human Services System (HHSS). HHSS is made up of three functional agencies, the Department of Health and Human Services (HHS); the Department of Health and Human Services Finance and Support (HHS/F&S); and the Department of Health and Human Services Regulations and Licensure (HHS/R&L). The State Medicaid authority is located in HHS/F&S. For more information about the HHS System visit <<http://www.hhs.state.ne.us/>>.

**Policy Cabinet:** The Nebraska Health and Human Services System (HHSS) Policy Cabinet governs this State of Nebraska agency. The Policy Cabinet consists of the three agency directors, a Policy

Secretary, and the Chief Medical Officer. Governor Mike Johanns (R) took office in January, 1999. He appoints the HHSS Policy Cabinet. The HHSS Policy Cabinet members are

- Chris Peterson is the NE Health and Human Services System Policy Secretary.
- Ron Ross, Director, NE Department of Health and Human Services (HHS).
- Dick Nelson, Director, NE Department of Health & Human Services Regulation & Licensure
- Steve Curtiss, Director, NE Department of Health and Human Services Finance & Support
- Dr. Richard Raymond is Nebraska's Chief Medical Officer.

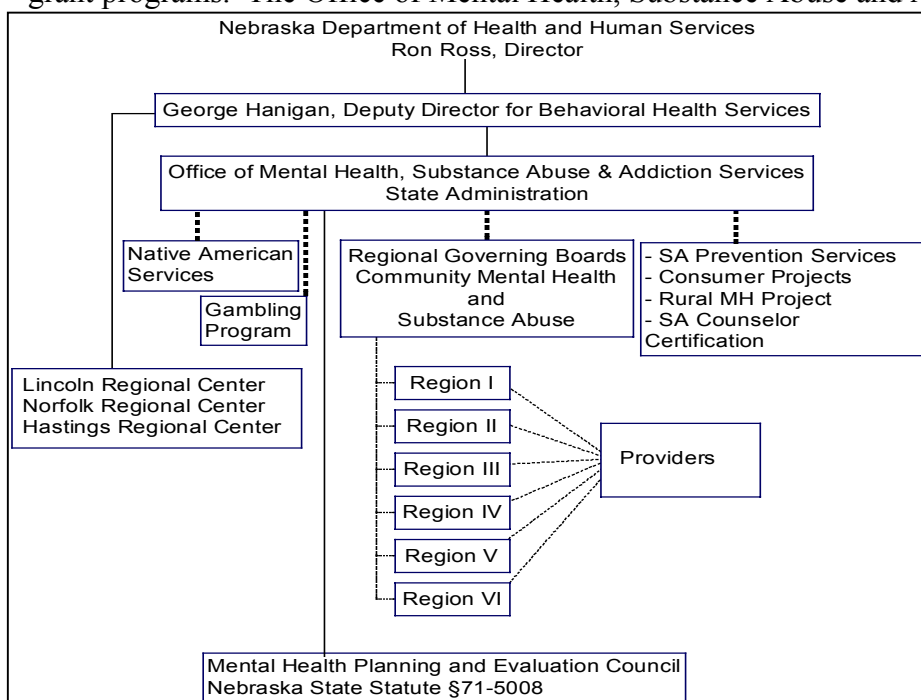
**HHS:** The Nebraska Department of Health and Human Services (HHS) has local offices across the state that are organized into three service areas. In addition, the Department oversees 10 facilities, including four Veterans' Homes, three regional centers (state psychiatric hospitals), two youth rehabilitation and treatment centers, and the Beatrice State Development Center. Organizational Structure for the Department of Health and Human Services (HHS) is

- Ron Ross, Director
- Dennis Loose Chief Deputy Director for Health and Human Services
- Mary Boschult Office of Administration
- George Hanigan Deputy Director for Behavioral Health Services

On June 23, 2003 it was announced that L. Blaine Shaffer, MD will now be serving as the Medical Director for HHS. Dr. Shaffer is under contract from the University of Nebraska Medical Center, Department of Psychiatry (Professor, Adult Psychiatry, Vice Chairman for Clinical Affairs). Most of Dr. Shaffer's time will be with the Behavioral Health Services Division, Regional Centers, Beatrice State Development Center and the Veteran Homes. His first day was July 1, 2003. Dr. Shaffer has been a member of the Mental Health Planning and Evaluation Council. Dr. Shaffer's role on the MHPEC was to represent "Service Providers" from the Region 6 (Omaha area). Dr. Shaffer's term on MHPEC ended on July 15, 2003. He did not seek re-appointment.

The Department of Health and Human Services was designated the State Mental Health Authority and Substance Abuse authority for administration of the mental health and substance abuse block grant programs. The Office of Mental Health, Substance Abuse and Addiction Services is located

within the Department of Health and Human Services.



This chart shows the Deputy Director for Behavioral Health's role with the Community Mental Health/Substance Abuse, Compulsive Gambling Services, and the three State Psychiatric Hospitals. Excluded from the table is the Deputy's role with Community Developmental Disability System, Beatrice State Developmental Center, and Aging & Disability Services.

HHS is a direct service

provider of mental health services through those three State Psychiatric Hospitals (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center).

### **Community Mental Health**

The Nebraska Comprehensive Community Mental Health Services Act (Neb. Rev. Stat. §§71-5001 to 71-5014) was passed in 1974. The Nebraska Department of Health and Human Services (HHS) is responsible for providing the functions contained in the 1974 Act. The State Mental Health Planning and Evaluation Council is authorized under this state statute (§71-5008). In a later section of Nebraska statute, the State Alcoholism and Drug Abuse Advisory Committee is established (see Neb. Rev. Stat. §71-5024 of the Alcoholism, Drug Abuse, and Addiction Services Act).

The Office of Mental Health, Substance Abuse and Addiction Services has 13 professional staff, plus Prevention Professional staff, support FTE; and student interns (part-time). The primary role involves **State administration and management of non-Medicaid public behavioral health services through Regional and direct service contracts**. In that capacity, the Office provides a state leadership role as the Mental Health Authority and State Substance Abuse Authority. This leadership role involves a number of different areas including but not limited to:

- Funding, contracting, & monitoring community mental health & substance abuse services
- Behavioral Health System Management and Information Management via Administrative Services Only contract with Magellan Behavioral Health.
- State Behavioral Health Standards (Regulations, Contracts, other related policy)
- Training/Technical Assistance
- Planning / Define Services / Establish Rates
- Professional Partner Services (Mental Health Children's Services only)
- Consumer Empowerment Projects
- Gambling Assistance Program
- Substance Abuse Prevention Programs
- Mental Health and Substance Abuse funding for Native American Tribes
- Substance Abuse Counselor Certification
- Mental Health Commitment Board Training
- Statewide MH Disaster Preparedness & Response / Critical Incident Stress Management
- Pre-admission Screening / Annual Resident Reviews
- State Mental Health Planning and Evaluation Council
- State Alcohol and Drug Abuse Committee
- State Gambling Commission
- Federal Grants Management including:
  - PATH Homeless Services
  - SA Needs Treatment Assessment
  - MH Data Infrastructure Grant
  - Regions 3 and 5 CMHS Children's Grants

## **CRITICAL GAPS / UNMET NEEDS**

**H. Description of critical gaps in services and unmet needs projected for the duration of the plan being submitted;**

**I. Identification of the source of data which was used to project critical service gaps and unmet needs.**

### **GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.**

The prevalence of mental illness is the estimated total number of cases of a disease in a given population at a specific time. The penetration rate is the number of individuals with these diseases being served by the public and private sectors in Nebraska.

#### **CHILDREN**

As with the adult definitions, the prevalence rate of serious emotional disturbance is defined as the estimated total number of cases of children diagnosed with SED in the state of Nebraska at a specific time. The penetration rate is the number of children with this diagnosis receiving services through the Nebraska Behavioral Health System (NBHS), Office of Protection and Safety System, including Child Welfare and Juvenile Justice Systems, and others receiving services funded by Medicaid or private insurance. Data on the prevalence rate of SED children indicates:

SED Youth Needing Mental Health Services	23,537
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Services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. Unfortunately, one way to access services for children is for parents to relinquish custody of their children, deeming them state wards, and making them eligible for services. Another circumstance is allowing children to fail to the point where they violate the law. Children then fall into one of the designated service categories and are able to access services. This is not an acceptable state of affairs. Appropriate service models are effective and available, but without adequate funding to serve children in need, we will continue to pay the price later by forcing children into higher levels of care and/or into the legal system.

Unfortunately, Nebraska does not have the capacity to determine the penetration rate of all systems for children with serious emotional disturbance. Because a number of systems (Nebraska Behavioral Health System, Medicaid, Office of Protection and Safety, including child welfare and Juvenile Justice, Education and Corrections) may provide some sort of mental health service for children with SED and their families, it is difficult to gather data as to an unduplicated count of children receiving services. An information system is not available which is able to synthesize data on children receiving services across multiple systems; data is not available on the number of children not receiving services. A relatively recent study on the prevalence estimate, people served and unmet need (WICHE, 2001) indicates that children in Nebraska with SED are relatively well served in comparison to adults. However, given the anecdotal data which indicates a large number of children needing services are not receiving them, one might theorize that some populations of children may be “over-served” while others remain unserved because they are outside the eligibility boundaries of child serving systems with adequate funding for mental health care.

Most significantly, the lack of penetration data makes it difficult to plan for services for children when the gaps are not readily apparent.

**Source:** Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003; Nebraska MHSIP Prevalence, Utilization and Penetration (WICHE Mental Health Program, 2001)

**ADULTS:** The US Department of Health and Human Services, Center for Mental Health Services (CMHS) estimates, using the U.S. Census Bureau 2000 data, the Number of Persons (Civilian Population) with Serious Mental Illness (SMI), age 18 and older is 67,701. The Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program. In FY2002, NBHS served 7,556 persons who were identified as having a Severe and Persistent Mental Illness (SPMI). Using these figures, 11.2% (67,701) of the people who SMI are served by NBHS.

In looking at these figures, it is important to remember the role of Medicaid, the Criminal Justice System, the private sector (health insurance and self pay) and other related areas in addressing the needs of these populations. Thus the gap here involves two areas:

1. Nebraska's capacity to determine the Prevalence and Penetration rate for individuals with mental illness.
2. The gap between the actual number of persons in need (prevalence) and the NBHS capacity to meet these needs (penetration rate).

**SOURCE:**

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- This is more fully discussed under Adult Criterion 2: Mental Health System Data Epidemiology.
- Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003
- Nebraska MHSIP Prevalence, Utilization and Penetration (WICHE Mental Health Program, 2001)

**GAP #2: DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION**

Additional assessment of the ability of adult providers to work successfully with transitioning is needed to ensure developmental appropriateness of services. Adult providers are often unwilling to serve younger adults as their developmental needs are different than older adults, and/or should be met in a different manner than older adults' needs. Nebraska Behavioral Health System data indicates that Three Mental Health age waivers were requested to authorize services for youth ages 17 & 18 who were unable to be served in youth systems. The Office of Mental Health, Substance Abuse and Addiction Services provides funding for youth in transition to adult mental health services through an age waiver program (for children 17 and 18,) allowing youth to access appropriate adult services that are traditionally unavailable to transition-aged youth. The burden is on the provider to communicate and provide a developmentally appropriate adaptation of the service to the transition-aged youth. Additional assessment of the ability of adult providers to work successfully with transitioning is needed to ensure developmental appropriateness of services.

**Source:** July 21, 2003 meeting of the Planning Team of the Office of Mental Health, Substance Abuse and Addiction Services; 2003 LB 433 Reports; NBHS Annual Age Waiver Summary

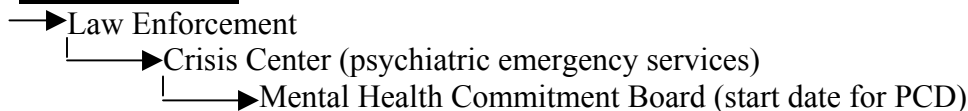
### **GAP #3: LACK OF ADEQUATE “STEP DOWN” SERVICES**

This is looking at the "consumer flow" of adults through the Nebraska Behavioral Health System (NBHS). This flow starts with the individual going to psychiatric emergency services, into inpatient for treatment, followed by lower levels of care suitable for the consumer's needs.

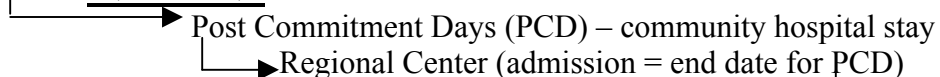
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#### **MENTAL HEALTH AND SUBSTANCE ABUSE -- CONSUMER FLOW**

##### **EMERGENCY**



##### **INPATIENT**



**RESIDENTIAL SERVICES** – Group Residential Beds – facility based, non-hospital or nursing home, group living with on site staff.

##### **NON-RESIDENTIAL MENTAL HEALTH SERVICES**

Independent Living in Residential Units (apartments, single room occupancy) that are affordable, decent, safe, and appropriate for people who are extremely low income with SMI with community mental health support services.

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There are a number of problems triggering this gap. Many involve the fragmented behavioral health system in Nebraska. There are a number of different funding streams such as Medicaid, NBHS, Protection & Safety, and private health insurance. Each funding stream has its own clinical and financial eligibility requirements. The funding levels do not provide enough incentives for individuals to select mental health as a career, leading to staffing shortages (see next gap).

These problems lead to a focus on public safety issues being a priority. Areas such as psychiatric emergency services are addressed. However, there are many problems here. Richard Young Center, a psychiatric inpatient facility in Omaha, closed by April 2003. The beds had been used to serve unstable or suicidal patients. The closing of Richard Young eliminated 34 percent of Omaha's inpatient mental health beds, exacerbating the current problems.

However, there is no good flow through the system, leading to "Post Commitment Days". "Post Commitment Days" (PCD) are defined as the number of days between the date of mental health board civil commitment to inpatient care at a Regional Center and the date of admission to the Regional Center. A statewide summary on "Post Commitment Days" shows in FY2002 there were 5,633 PCD and in FY2003 a total of 4,805 PCD. This shows a decrease of 828 (15%) from FY2002 to FY2003. However, there are still problems.

The billings recently sent by the Lincoln hospital BryanLGH Medical Center provides another example of the current Post Commitment Days problem. BryanLGH said they were trying to get reimbursed for unpaid services by putting pressure on state and local governments to create a workable system for adults with serious mental illnesses. Starting in mid-June 2003, BryanLGH billed:

- (1) More than 20 counties and cities for a total of \$1,055,000 for the care of 498 patients over more than two years, from January 2001 to April 2003;
- (2) \$883,859.90 to the Lincoln Police Department for the care of hundreds of patients who were waiting at a hospital for a room at the county crisis center or a state psychiatric hospital; and Lancaster County for about \$930,000, charges duplicate many of the patients on the Police Department bill.

The front end of the cycle is triggered when there is not enough housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness. Housing problems for people with serious mental illness lead to increased demand for emergency psychiatric services, increased length of stay in inpatient psychiatric services, and homelessness.

The need for housing in community settings that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness would help to address this. With this housing, an adequate supply of the lower levels of care for mental health services needs to be included.

#### **SOURCE:**

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. (Lincoln, NE) which is planning focused on people who are extremely low income with serious mental illness needing housing. There are two projects covered in the contract:
  - Project #1 statewide consumer housing need study (July 24, 2003) and
  - Project #2- planning in four communities Omaha, Lincoln, the Norfolk Area & Tri-City Area (Hastings, Grand Island, and Kearney) (in process).
- "Dispute with Bryan LGH over mental health bill spotlights LPD headache" July 27, 2003, Lincoln Journal Star
- Omaha World-Herald; February 14, 2003 - Lincoln Journal Star; February 26, 2003
- HHS Office of Mental Health, Substance Abuse and Addiction Services, July 25, 2003.
- Transition Project Charter (as of May 22, 2002) which is designed to impact the transition of consumers between the Regional Centers to community-based services through the development of processes and services.
- Mental Health Housing Planner Request For Proposals released on May 1, 2002.
- "Nebraska Mental Health Housing Coalition Planning Meeting" held on January 29, 2002.

#### **GAP #4: INFORMATION SYSTEM IS INADEQUATE**

There is a need to work on improving the management information systems used by the Office of Mental Health, Substance Abuse and Addiction Services. At minimum, there is a need to check for accuracy and provide feedback on data quality. NBHS, Medicaid and the Regional Centers each have their own data systems. There is no mechanism linking all three systems together.

As a result, there are various problems. These include being unable to effectively track consumers through the system, multiple requirements for data entry of the same information by the provider due to each funding source's needs, and the inability to receive timely and accurate reports on utilization of services.

The long term goal is to develop a single management information system to cover Community-based Mental Health, Substance Abuse, and the Regional Centers (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). This includes improving provider participation in the information system. Such efforts are expected to result in improving the quality of data in the

NBHS Management Information System. This also includes the need to improve the capacity to measure service capacity. This improved ability would be useful in managing the system as well as tracking gaps in services. It would also help in establishing performance measures. Under the current operations, it is very difficult to measure outcomes in relationship to funds expended.

In general, the data will be used to answer questions such as “who are we serving?” “What services are they getting?” and “What results were produced?”.

**SOURCE:**

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Nebraska Mental Health Data Infrastructure Grant Application (First Year Application / June 19, 2001; Second Year Grant Renewal Application / March 18, 2002; and Third Year Grant Renewal Application / March 21, 2003)
- Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003

**GAP #5: SHORTAGE OF CREDENTIALLED & ADMINISTRATIVE STAFF**

There is a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, licensed mental health practitioners (LMHP), nurses and Certified Alcohol/Drug Abuse Counselors (CADAC). With all the increasing expectations on what the Nebraska Behavioral Health System (NBHS) needs to address, there also needs to be adequate supply of administrative personnel at all levels of operations.

**LACK OF EXPERTISE AVAILABLE TO WORK WITH PERSONS WITH DUAL DISORDERS**  
Substance abuse and dependence may go undiagnosed and untreated in adults with serious mental illness and children with serious emotional disturbance. Assessing substance abuse disorders is a key issue here.

This is especially a problem for children with serious emotional disturbance. All of the Nebraska Behavioral Health Regions throughout the state of Nebraska have expressed the need for more qualified staff and professionals, more specialized training for all non mental health staff and professionals who work with children diagnosed with a dual disorder (mental health and substance dependence).. There is a need to expand services in order to serve more youth in rural and frontier areas. Treatment professionals and educators, as well as parents in Nebraska would benefit from more education and training to assess and refer children for dual disorder treatment, and earlier intervention and assessment services. Furthermore, the need for more cooperation and communication between the mental health and substance abuse treatment systems, as well as other child serving systems.

**Source:** 2003 LB433 Report; Source: Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003.

Comments from: Donald E. Fischer, MD, DABFM, C.A.S.A.M  
Private Practice, Scottsbluff, NE and Member of the MHPEC Executive Committee  
(e-mail: 08/05/2003 – Subject: NMA - TASK FORCE)

"I have been following your/our discussions about the C.A.D.A.C.s with a lot of interest. I have treated a lot of patients with addictions for thirty years and as one of the few certified medical addictionists in our state I've had not only considerable experience with addictive disorders, but also observed physicians and other practitioners trying to diagnosis and treat these illnesses.

"In response to several key issues raised among us so far:

- The average physician without any special training or clinical experience may be able to diagnosis alcohol (and other) dependencies but not be prepared to recommend the level of treatment needed, depending on patient age, chronicity, prior treatment outcome, support system, etc. Therefore, additional training is usually needed and the Nebraska Medical Association Mental Health Task Force is in a unique position to make meaningful recommendations.
- My opinion is the same for a licensed psychologist without specific training in addictive and compulsive disorders. Again, it's not just making a diagnosis, it's the need to have experience with the various levels of treatment needed and how to put together a comprehensive program using the limited resources available. Issues such as medication management and physical assessment would not apply to them.
- As many out state physicians point out the scarcity of residential or inpatient treatment makes this process even more difficult for the novice physician or psychologist.

"After having said all that, my firm opinion as a psychiatrist and medical addictionist, is that C.A.D.A.C.s are not qualified to go beyond basic substance dependence assessment. By training and licensure they are not qualified to recognize comorbid disorders such as Bipolar disorders, ADDH, OCD and other anxiety disorders, Axis II disorders, etc. Medical conditions accompanying substance dependence are beyond their purview, as well as the role of psychoactive medications (both dependency-producing and those needed in treatment, i.e.: antidepressants). I realize this is not news to you.

"If these allied professionals are not qualified to make a comprehensive diagnosis, how can they be the exclusive assessors of substance dependencies in the Nebraska Justice System?

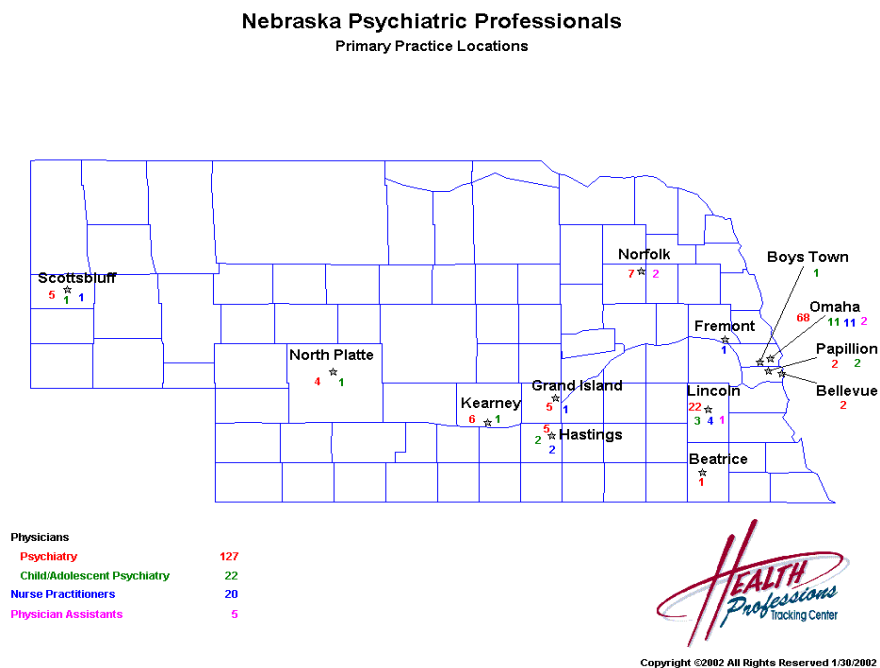
"In practice, I collaborate routinely with some C.A.D.A.C.s in Region I providing medical-psychiatric diagnosis to complement their assessment of the individual's alcohol and other drug impairment. Frequently, a psychologist provides screening tests especially if there are forensic issues involved."

(End of comments from Donald E. Fischer)

#### PSYCHIATRIC SHORTAGE AREAS

Twenty-one of Nebraska's 93 counties have no licensed mental health professionals, including psychiatrists, psychologists, social workers, counselors or marriage and family therapists. Another 24 counties only have one mental health professional.

## In Nebraska, Psychiatric Professionals, Primary Practice Locations:



	Psychiatry		Child / Adol. Psychiatry		Nurse Practitioners		Physician Assistants		Totals	
	#	%	#	%	#	%	#	%	#	%
Region 1	5	4%	1	5%	1	5%	0	0%	7	4%
Region 2	4	3%	1	5%	0	0%	0	0%	5	3%
Region 3	16	13%	3	14%	3	15%	0	0%	22	13%
Region 4	7	6%	0	0%	0	0%	2	40%	9	5%
Region 5	23	18%	3	14%	4	20%	1	20%	31	18%
Region 6	72	57%	13	62%	12	60%	2	40%	99	57%
Totals	127	100%	21	100%	20	100%	5	100%	173	100%

The supply of Nebraska Psychiatric Professionals is, based on their primary practice locations, as of January 30, 2002, according to the University of Nebraska Medical Center's Health Professions Tracking Center:

- Region 6, including the Omaha Metro Area
- Region 5, including the Lincoln Metro Area
- Region 4, the city of Norfolk
- Region 3, including the cities of Hastings, Grand Island, and Kearney
- Region 2, the city of North Platte
- Region 1, the city of Scottsbluff

On July 2003, the U.S. Department of Health and Human Services (DHHS) lists over 70 percent of Nebraska's counties (66/93) to be designated as federal Mental Health Professional Shortage Areas (MHPSAs). Based on the 2000 census data, the population within these shortage areas (N= 853,817) exceeds 49 percent of the state's total population. One facility, the Hastings Regional Center, has also been designated as a federal mental health care HPSA.

On June 12, 2003, the Nebraska Office of Rural Health and Primary Care submitted an application to the federal Shortage Designation Branch to request Catchment Area 3 (also known as Region 3) to be given the designation as a federal Mental Health Professionals Shortage Area. It is anticipated that this will expand the federally designated Mental Health Professional Shortage Areas to cover 95 percent of Nebraska's counties (88/93). This will leave only 5 of the 93 counties in Nebraska (Catchment Area 6) as not having a federal Mental Health Professional Shortage Area designation.

In nursing, 37 of 93 Nebraska's counties are considered to have a shortage, as of 11/04/02. The list of "Nursing Shortage County" is from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions.

Mental health is chronically under funded. To address the staffing issues, models of care must be adopted that allow the system to use the available expertise to the greatest extent possible. For example, general practice physicians, advanced practice nurses, and physician's assistants may be able to fill the roles of psychiatrists. In non-medical areas Licensed Mental Health Practitioners and Psychologists have filled traditional therapy roles. The use of physician extenders, non-physician program directors with psychiatric consultation, shared consumer management duties with other professions, and consultation over the internet are but a few of the ways that psychiatric expertise can be used.

Blaine Shaffer, MD (HHS Department of Health and Human Services Medical Director; the University of Nebraska Medical Center, Department of Psychiatry; and former member of the Mental Health Planning and Evaluation Council) commented on the shortage of psychiatrists in Nebraska.

"The point is that we need psychiatrists, not others acting as psychiatrists. One issue involves in medical students not choosing psychiatry is their perception that you don't have to be a trained psychiatrist to do psychiatry. Physician extenders are very helpful but should not replace psychiatrists.

"Telepsychiatry could be a way for psychiatrists and other providers to collaborate and provide quality care for people in shortage areas. This modality is also currently underfunded."

For more information on the federal Health Professional Shortage Area status contact Thomas Rauner in the HHS Office of Rural Health and Primary Care (402-471-0148).

#### **SOURCE:**

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- 2003 LB433 Report
- Office of Mental Health, Substance Abuse and Addiction Services Planning Team meeting, July 21, 2003.
- Blaine Shaffer, MD, HHS Dept of Health and Human Services Medical Director; July 22, 2003
- "Rural Mental Health Aid Sparse" Lincoln Journal Star; Tuesday July 1, 2003

- Nebraska HHS Office of Rural Health & Primary Care (July 2003.) This office has the responsibility to review (and submit if appropriate) federal shortage area applications to the Shortage Designation Branch. This includes the Psychiatric Health Professional Shortage Area.
- University of Nebraska Medical Center's Health Professions Tracking Center; Nebraska Psychiatric Professionals; January 30, 2002.
- Nebraska Mental Health Planning and Evaluation Council meetings on August 16, 2001, February 4, 2002, and August 8, 2003.

#### **GAP #6: MEDICATION ACCESS**

This gap involves many things related to providing access to psychiatric medications for persons with serious mental illness or youth with severe emotional disturbance.

Below is a Medicaid report covering calendar year 2001 (the most complete year).

Costs for Medicaid Eligibles with Serious Mental Illness (SMI) by Age Group, Calendar Year 2001 ("Medicaid SMI Report" July 23, 2003)						
Age Group <sup>1</sup>	Medicaid Eligibles with SMI (Eligibility Years) <sup>2</sup>	Costs				
		SMI Outpatient <sup>3</sup>	Other Outpatient <sup>3</sup>	Total Outpatient <sup>3</sup>	All Drugs <sup>4</sup>	Total
19-21	491	\$211,520	\$540,678	\$752,198	\$961,683	\$1,713,881
22+	9,829	\$5,882,331	\$8,834,716	\$14,717,047	\$42,706,791	\$57,423,838
Total	10,320	\$6,093,851	\$9,375,394	\$15,469,245	\$43,668,474	\$59,137,719

Age Group <sup>1</sup>	Medicaid Eligibles with SMI (Eligibility Years) <sup>2</sup>	Costs per Eligibility Year with SMI				
		SMI Outpatient <sup>3</sup>	Other Outpatient <sup>3</sup>	Total Outpatient <sup>3</sup>	All Drugs <sup>4</sup>	Total
19-21	491	\$431	\$1,101	\$1,532	\$1,959	\$3,491
22+	9,829	\$598	\$899	\$1,497	\$4,345	\$5,842
Total	10,320	\$591	\$909	\$1,499	\$4,232	\$5,731

1. Age at time of first outpatient visit (after 19th birthday) in CY 2001
2. A Medicaid Eligible was said to have SMI if he/she was at least 19 years of age and had a primary or secondary diagnosis of 295-298.9 in an outpatient setting during CY 2001
3. Costs incurred at crisis/respite care, group residential, and residential facilities are excluded
4. Cost of all prescription drugs (not only psychiatric medications)

Please note:

- the drug costs are not broken down into "psychiatric medications" and "others". The report calculates the costs for all drugs prescribed for eligibles with SMI.
- the total cost (for both outpatient services and drugs) for one person with SMI in Medicaid for one year (2001) was \$5,730.

This is from the MHPEC Strategic Planning meeting on April 12, 2002.

- "Medication Access" is an issue because:
  - there is not a stable reliable source of medications for people with mental illness.
  - no clear cut mandate on who is to pay for what. Everyone wants to be the one who pays last dollar.

- "Medication Access" Theme: Reducing the barriers to getting the right drug to the right recipient in the right dosage by the right route at the right time to consumers in community mental health settings.

There are many groups involved in this medication access issue ranging from

1. Consumers, family members
  2. county level services: Counties, County Attorneys, Mental Health Commitment Boards, Sheriffs (transportation), veteran service center, county corrections
  3. Service Providers: Regional Centers, Community Mental Health providers, Emergency Care Centers, Housing providers; Pharmacies, Physicians, and other health care practitioners, Nebraska Medical Association's mental health task force, Regional Governing Boards, Law enforcement, Corrections ...
  4. Payers: Medicaid, Medicare, Managed Care Companies, Private insurance companies, SSI, SSDI, HHS Office of Mental Health, Substance Abuse and Addiction Services
  5. Resources: Drug companies, Pharmacies ...
  6. Advocates / allies: Nebraska Association of Behavioral Health Organizations (NABHO), National Alliance for the Mentally Ill-Nebraska (NAMI-NE), and Mental Health Associations of Nebraska.
- LB 1148 (2002) PRESCRIPTION DRUG ASSISTANCE required the Health and Human Services Committee, on or before December 1, 2002, to conduct research and provide recommendations to the Nebraska Legislature and the Governor on the topic of prescription drug assistance. The bill required the committee to consult with members of the Legislature, the Governor, the Nebraska Health and Human Services System, the Department of Insurance, the Department of Revenue, political subdivisions, area agencies on aging, pharmacists, pharmaceutical manufacturers, advocates for the elderly and persons with mental illness, health care providers, insurance companies, and other interested parties.
  - One source to pay for psychiatric medications is "LB95". This is an indigent outpatient, prescription medicine program administered by the Department of Health and Human Services. It is authorized under Neb. Rev. Stat. §83-380.01 (Laws 1981, LB 95, § 25). In the chart below "FY2003 Community Mental Health Funding / Office Of Mental Health, Substance Abuse And Addiction Services", note the line item "Indigent Medications" (through Regional Centers) is \$600,000 in FY2003.
  - Summary on Medication Support Oriented Comments from the "ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).
    - Many times know someone needs to get into hospital, but are not yet to the crisis level of MI & Dangerous. If not eligible for Medicaid or Medicare, it is real hard to get money for the medications. If you can get the medications you can prevent the need for the hospital bed.
    - substance abuse is self medication ... abuse and violence may come with it.
    - access to insurance company - need 20 phone call to get care ... a barrier to services
    - working poor - person is not eligible for Medicaid because they work but do not earn enough to pay for the medication. With Medicaid you can usually find someone who can take care of the individual ... the working poor need some mechanism to access the care.
    - One person testified he was on 8 different medication in last 15 years.
    - Trouble in rural NE not the same in urban NE ... shortage of psychiatrists.

## **SOURCE**

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- "Medicaid SMI Report" was prepared by Brett Foley, Statistical Analyst, Nebraska HHSS - Epidemiology; (July 23, 2003).
- Medication Accessibility discussed at the Mental Health Planning & Evaluation Council Strategic Planning Meeting - April 12th, 2002.
- Mental Health Planning & Evaluation Council June 14TH, 2002 Videoconference Meeting
  - report from April 12 Strategic Planning meeting
  - Jeff Santema, Legal Counsel, Health and Human Services Committee, Nebraska Legislature: Report on Legislative Interim Studies pertinent to mental health
- ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).

## **GAP #7: CULTURALLY COMPETENT SERVICES**

A critical service gap in the adult and children's mental health system appears to be cultural and linguistically competent services. A language barrier has arisen in several communities across Nebraska, rural and urban, due to the increase in minority populations living across the state. There is lack of access to bi-lingual mental health professionals and family support services. Services which recognize the unique cultural needs of all Nebraskans are not always available. This lack of access should be recognized and culturally competent services should be developed. The new immigrant/refugee populations in Nebraska also needs to be addressed.

Jose J. Soto said, "Despite the rapid growth of the Hispanic/Latino population in our rural communities, public sector response to the mental and behavior health service needs of that population have been slow to come and not commensurate with the growth, verified needs and often dire circumstances of this population. Included in the latter are the harsh realities of chronic poverty, the lack of adequate and stable medical care, cultural isolation, racism, and quite frequently language barriers that make available services effectively inaccessible."

source:

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Jose J. Soto, Vice President for AA/Equity/Diversity, Southeast Community College Area, Lincoln, NE; July 2, 2003; e-mail to the six Regional Program Administrators  
Subject: Unmet Mental Health Needs.
- December, 2001 Report: Nebraska's Public Behavioral Health System for Children and Their Families: Identification of Quantity of Services, Quality of Services, Gaps in Services and Priorities for Service Development  
Nebraska Department of Health and Human Services; Region 1 Mental Health and Substance Abuse Administration; Region 2 Human Services; Region 3 Behavioral Health Services; Region 4 Behavioral Health System; Region 5 Systems; Region 6 Behavioral Health Care

## **Gap #8: Elderly population not being served...**

Another important gap is mental health services to elders.

- In FY2002, the community mental health (Magellan data) persons served data showed people age 65-74 years equaled 516 (1.53%), and 75 + years equaled 288 (0.85%).
- In FY2002, the Regional Centers (AIMS data) persons served showed people age 65-74 years equaled 32 (2.3%), and 75+ years equaled 15 (1.1%)

Meanwhile, the Nebraska Census Data shows (FY2000) shows the people age 65-74 Years equals 115,699; age 75-84 equals 82,543; and age 85+ equals 33,953. The total age 65 years and over

equals 232,195 (13.6%).

- Nebraska ranked 12th nationally in percentage of population age 65 or older.
- Nebraska ranks sixth in the nation when considering percentage of its older population in the 75-plus age group.
- The state ranks fourth nationally when considering percentage of its older population who are 85-plus.

While overall, 18.4 percent of the state's population is comprised of people 60 and older, some counties in Nebraska have much higher rates of older citizens. The counties with the highest over 60 population are Pawnee (35 percent), Webster (33 percent), Franklin (33 percent), Furnas (33 percent), Thayer (32 percent) and Hooker (32 percent).

Source:

- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- web site for the Eastern Nebraska Office on Aging, Omaha, NE  
<http://www.enoa.org/demographics/index.html>
- U. S. Bureau of the Census, Census of Population, decennial, and March 2001 as reported in the "Nebraska Databook" <<http://info.neded.org/databook.php?cont=sb&ttle=Population>>

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## **SECTION III – STATE PLAN**

### **A. Fiscal Planning Assumptions for Adults and Children**

The fiscal planning assumption for the Community Mental Health Services (CMHS) Block Grant is based on the final allocation from FY2003:

\$2,042,087	FY2003 base
\$ 57,794	increase
\$2,099,881	Final Allocation

STATE COMMUNITY MENTAL HEALTH AID SAME AS LAST YEAR – The Legislature needed to make massive cuts to the State of Nebraska budget. However, the state aid for FY2004 community mental health remained the same as previous fiscal year.

In the previous fiscal year, only state General Funds were reported. This year, the Mental Health aid being reported includes the Federal Mental Health Block Grant, state General Funds and "tobacco settlement funds designated for behavioral health services, expended or allocated to community mental health.

#### **Mental Health Block Grant Funds**

##### **TOTAL FUNDS BY TARGET POPULATION**

	CMHS Block Grant	%
Adult Residential, Rehab, and Support Services	\$492,614	23.5%
Adult Treatment Services	\$596,701	28.4%
Total Services for SPMI/SMI Adults	\$1,089,315	51.9%
Services for SED Children/Youth	\$847,465	40.4%
Peer Review	\$3,200	0.2%
Rural Service Equity +	\$54,907	2.6%
State Administration (5%)	\$104,994	5.0%
FY2004 TOTAL FUNDS (100 %)	\$2,099,881	100.0%

+Rural Service Equity funds are unallocated at this time. Allocation occurs as needed to rural areas.

In the section regarding "Rehab & Support Services," is a row on "Vocational Rehabilitation". The State funds in Vocational Rehabilitation are used to match federal funds from Department of Education Division of Vocational Rehabilitation through a State Cooperative Agreement. The \$279,668 **State funds** match approximately **\$1,319,000 federal VR funds** on a **21% State to 79% federal match** rate to serve persons with mental illness in vocational rehabilitation services.

**\*\* Region 3 Professional Partner fund totals DO NOT INCLUDE the CMHS Children's Grant for Professional Partner Services (\$1,240,628).**

The **Peer Review**, per Section 1943 (\$3,200), is completed by the Nebraska Association of Behavioral Health Organizations (NABHO) under contract with HHS Office of Mental Health, Substance Abuse and Addiction Services. The Peer Review process is utilized to assess quality and appropriateness of treatment services in Nebraska. It is used as a means to help identify trends, arrange for technical assistance, and help identify "best practices". Specific results of the site visits are only shared between program reviewed, the person conducting the peer review, and the committee that compiles the final report. The Office of Mental Health, Substance Abuse and Addiction Services receives only an aggregated report.

**TABLE 1: FY2004 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS (Rev 8/25/03)  
CONTRACTED WITH REGIONS FOR COMMUNITY MENTAL HEALTH SERVICES**

		REGIONS						
		1	2	3	4	5	6	TOTALS
SERVICES								
Adult Residential, Rehab, and Support Services	** Community Support - MH		\$ 75,258	\$ 15,240	\$ 34,829		\$ 10,944	\$ 136,271
	** Day Rehabilitation		\$ 57,033				\$ 22,176	\$ 79,209
	** Psych Residential Rehab						\$ 131,400	\$ 131,400
	Vocational Support	\$ 1,440		\$ 15,534	\$ 38,800			\$ 55,774
	Day Support	\$ 33,360		\$ 41,600				\$ 74,960
	Dual Residential (SPMI/CD)					\$ 15,000		\$ 15,000
	<i>Subtotal</i>	\$ 34,800	\$ 132,291	\$ 72,374	\$ 73,629	\$ 15,000	\$ 164,520	\$ 492,614
Adult Treatment Services	Day Treatment					\$ 20,000		\$ 20,000
	OP Assessment & Therapy - MH	\$ 29,419		\$ 43,134	\$ 35,066	\$ 144,000	\$ 173,708	\$ 425,327
	OP Assessment & Therapy - Dual			\$ 8,928				\$ 8,928
	Medication Management	\$ 6,032	\$ 40,504	\$ 50,910			\$ 45,000	\$ 142,446
	<i>Subtotal</i>	\$ 35,451	\$ 40,504	\$ 102,972	\$ 35,066	\$ 164,000	\$ 218,708	\$ 596,701
Children's Services	C/Y Day Treatment	\$ 38,000		\$ 42,856				\$ 80,856
	C/Y Therapeutic Consult (School)		\$ 15,000			\$ 73,000		\$ 88,000
	C/Y Professional Partner		\$ -	\$ 50,000	\$ 80,000	\$ 150,921	\$ 200,000	\$ 480,921
	C/Y Prof Partner/School Wraparound	\$ 78,000			\$ 83,850			\$ 161,850
	C/Y Intensive Outpatient					\$ 35,838		\$ 35,838
	<i>Subtotal</i>	\$ 116,000	\$ 15,000	\$ 92,856	\$ 163,850	\$ 259,759	\$ 200,000	\$ 847,465
	<b>REGION BLK GRT FUND TOTALS</b>	\$ 186,251	\$ 187,795	\$ 268,202	\$ 272,545	\$ 438,759	\$ 583,228	\$ 1,936,780

\*\* Serving non medicaid eligible consumers

TABLE 2: FY2004 COMMUNITY MENTAL HEALTH FUNDING

<b>FUNDING SOURCE</b>	<b>State General \$</b>	<b>Tobacco Rate \$</b>	<b>Tobacco New/Exp \$</b>	<b>Tobacco Psych Emerg \$</b>	<b>Fed Blk Grt \$</b>	<b>Other Fed \$</b>	<b>BH/MRO \$</b>	<b>TOTAL \$</b>
<b>REGIONAL CONTRACTS</b>		<b>Tobacco Settlement Cash Funds</b>						
1	\$1,150,331	\$98,914	\$114,200	\$48,898	\$186,251	\$0	\$514,050	\$2,112,644
2	\$962,364	\$76,105	\$392,661	\$48,153	\$187,795	\$0	\$137,045	\$1,804,123
3	\$2,882,753	\$217,928	\$0	\$109,818	\$268,202	\$0	\$507,989	\$3,986,690
4	\$2,295,898	\$221,549	\$175,185	\$113,304	\$272,545	\$0	\$921,198	\$3,999,679
5	\$4,121,571	\$368,957	\$444,033	\$525,797	\$438,759	\$0	\$1,088,680	\$6,987,797
6	\$8,565,026	\$750,538	\$1,711,757	\$654,030	\$583,228	\$0	\$1,021,168	\$13,285,747
<i>SUBTOTAL REGIONAL \$</i>	<b>\$19,977,943</b>	<b>\$1,733,991</b>	<b>\$2,837,836</b>	<b>\$1,500,000</b>	<b>\$1,936,780</b>	<b>\$0</b>	<b>\$4,190,130</b>	<b>\$32,176,680</b>
<b>OTHER STATE CONTRACTS</b>								
Native American - Omaha Tribe	\$207,498	\$0	\$0	\$0	\$0	\$0	\$0	\$207,498
Native American - Ponca Tribe	\$67,729	\$0	\$0	\$0	\$0	\$0	\$0	\$67,729
Native American - Santee Sioux Tribe	\$70,033	\$0	\$0	\$0	\$0	\$0	\$0	\$70,033
Native American – Winnebago Tribe	\$143,990	\$0	\$0	\$0	\$0	\$0	\$0	\$143,990
Central NE Fam/Youth CMHS Grant (Rg3)	\$0	\$0	\$0	\$0	\$0	\$1,240,628	\$0	\$1,240,628
MH Homeless Services PATH Grant	\$0	\$0	\$0	\$0	\$0	\$288,000	\$0	\$288,000
Lancaster Co Fam/Youth CMHS Grt (Rg 5)	\$0	\$0	\$0	\$0	\$0	\$1,500,000	\$0	\$1,500,000
ASO/Managed Care Contract	\$1,449,296	\$0	\$0	\$0	\$0	\$0	\$0	\$1,449,296
Peer Review	\$0	\$0	\$0	\$0	\$3,200	\$0	\$0	\$3,200
Consumer / Family Org Projects	\$161,500	\$0	\$0	\$0	\$0	\$0	\$0	\$161,500
Indigent Medications	\$1,500,000	\$0	\$0	\$0	\$0	\$0	\$0	\$1,500,000
Rural MH Crisis Counseling Voucher Services	\$150,000	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000
MH Statewide Training	\$75,000	\$0	\$0	\$0	\$0	\$0	\$0	\$75,000
<i>SUBTOTAL OTHER Funds</i>	<b>\$3,825,046</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$3,200</b>	<b>\$3,028,628</b>	<b>\$0</b>	<b>\$6,631,874</b>
Unallocated/Cash Flow/Rural Service Equity					<b>\$54,907</b>			<b>\$54,907</b>
State Administration (5% BlkGrt)					<b>\$104,994</b>			<b>\$104,994</b>

<b><i>TOTAL \$</i></b>	<b>\$23,802,989</b>	<b>\$1,733,991</b>	<b>\$2,837,836</b>	<b>\$1,500,000</b>	<b>\$2,099,881</b>	<b>\$3,028,628</b>	<b>\$4,190,130</b>	<b>\$38,968,455</b>
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**TABLE 3: FY2004 FUNDED MENTAL HEALTH SERVICES BY REGION** Rev 8/25/03

	<b>REGION</b>	<b>1</b>	<b>2</b>	<b>3 **</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>TOTAL</b>
	<b>SERVICES</b>							
<b>Rehab &amp; Support Services</b>	Community Support – MH	\$274,385	\$496,093	\$525,485	\$582,566	\$2,033,433	\$963,476	\$4,875,438
	Day Rehabilitation	\$340,560	\$418,888	\$862,600	\$1,033,599	\$611,177	\$2,499,586	\$5,766,410
	Psych Residential Rehab			\$271,059	\$669,617	\$482,968	\$2,789,785	\$4,213,429
	Assertive Com Tx (ACT)						\$988,785	\$988,785
	Vocational Rehabilitation ***	\$11,449		\$70,502	\$17,592		\$179,825	\$279,368
	Vocational Support	\$1,625		\$34,615	\$89,216	\$10,418		\$135,874
	Day Support	\$73,142	\$38,700	\$114,918	\$7,729			\$234,489
	Dual Residential (SPMI/CD)					\$326,548		\$326,548
	Flex Funds – MH	\$9,000	\$9,000	\$21,000	\$18,000	\$27,000	\$10,000	\$94,000
	<b>Subtotal</b>	<b>\$710,161</b>	<b>\$962,681</b>	<b>\$1,900,179</b>	<b>\$2,418,319</b>	<b>\$3,491,544</b>	<b>\$7,431,457</b>	<b>\$16,914,341</b>
<b>Treatment Services</b>	Acute Inpatient/Secure Residential	\$300,000					\$483,428	\$783,428
	Day Treatment – Adults					\$23,809	\$136,000	\$159,809
	Outpatient Therapy – MH [Ind, Grp, Fam)	\$304,447	\$151,787	\$301,777	\$237,855	\$602,501	\$529,629	\$2,127,996
	Outpatient Therapy – Dual [Ind, Grp, Fam)			\$39,219				\$39,219
	Psychological Testing			\$14,513				\$14,513
	Medication Management	\$6,484	\$93,178	\$91,158	\$27,520	\$119,399	\$108,941	\$446,680
	Rural/Minority Guarantee & Cap Dev			\$95,404	\$129,027	\$81,964	\$200,000	\$506,395
	<b>Subtotal</b>	<b>\$610,931</b>	<b>\$244,965</b>	<b>\$542,071</b>	<b>\$394,402</b>	<b>\$827,673</b>	<b>\$1,457,998</b>	<b>\$4,078,040</b>
	24 hour Clinician on call	\$10,094		\$8,009		\$222,283	\$225,658	\$466,044
	Crisis Assessment/Evaluation	\$63,425			\$23,280			\$86,705
	Urgent Medication Management						\$58,000	\$58,000
	Urgent Outpatient Therapy – MH						\$329,500	\$329,500
	Crisis Response Teams	\$90,000	\$180,476	\$106,326	\$134,636			\$511,438
	Crisis Respite		\$6,600	\$14,296	\$32,217		\$279,422	\$332,535
	Emergency Community Support	\$58,780		\$162,000	\$57,205	\$29,440	\$80,720	\$388,145

	Emergency Stabilization and Treatment						\$1,166,627	\$1,166,627
	EPC Services	\$106,545	\$101,265	\$408,652	\$344,375	\$865,490	\$534,634	\$2,360,961
	Post Commitment Day Treatment	\$48,898	\$48,153	\$109,818	\$113,304	\$525,797	\$654,030	\$1,500,000
	<b>Subtotal</b>	<b>\$377,742</b>	<b>\$336,494</b>	<b>\$809,101</b>	<b>\$705,017</b>	<b>\$1,643,010</b>	<b>\$3,328,591</b>	<b>\$7,199,955</b>
<b>Children's Services</b>	C/Y Day Treatment	\$40,850		\$51,655				\$92,505
	C/Y Therapeutic Consult (School)		\$16,125			\$89,848		\$105,973
	C/Y Med Mgmt			\$5,375				\$5,375
	C/Y Respite Care						\$57,671	\$57,671
	C/Y Professional Partner **	\$125,775	\$150,930	\$485,315	\$318,630	\$480,440	\$876,770	\$2,437,860
	C/Y Prof Partner/School Wraparound	\$83,850			\$83,850			\$167,700
	C/Y Outpatient Therapy - MH (Ind, Grp, Fam)	\$100,334	\$64,888	\$52,458	\$31,446	\$260,805	\$16,125	\$526,056
	C/Y Home Based Therapy			\$46,215				\$46,215
	C/Y Intensive Outpatient					\$46,828		\$46,828
	C/Y Assessment/Evaluation ONLY - MH					\$117,224		\$117,224
	C/Y Crisis Inpatient			\$17,424				\$17,424
	C/Y Rural/Minority Guarantee & Cap Dev			\$56,292				\$56,292
	<b>Subtotal</b>	<b>\$350,809</b>	<b>\$231,943</b>	<b>\$714,734</b>	<b>\$433,926</b>	<b>\$995,145</b>	<b>\$950,566</b>	<b>\$3,677,123</b>
	Reg Youth System Coordination	\$18,000	\$18,000	\$20,605	\$18,015	\$30,425	\$38,636	\$143,681
	Reg Emergency System Coordination	\$45,000	\$10,040		\$30,000		\$78,000	\$163,040
	Reg Consumer Initiative						\$500	\$500
	<b>Subtotal</b>	<b>\$63,000</b>	<b>\$28,040</b>	<b>\$20,605</b>	<b>\$48,015</b>	<b>\$30,425</b>	<b>\$117,136</b>	<b>\$307,221</b>
	<b>REGION FUND TOTALS</b>	<b>\$2,112,643</b>	<b>\$1,804,123</b>	<b>\$3,986,690</b>	<b>\$3,999,679</b>	<b>\$6,987,797</b>	<b>\$13,285,748</b>	<b>\$32,176,680</b>

\* The State funds in Vocational Rehabilitation are used to match federal funds from Dept of Education Division of Vocational Rehab through a State Cooperative Agreement. The \$279,668 State funds match approximately \$1,319,000 federal VR funds on a 21% State to 79% federal match rate to serve persons with mental illness in vocational rehabilitation services.

\*\* Professional Partner fund totals DO NOT INCLUDE the Reg 3 CMHS Children's Grant for Professional Partner Services (\$1,240,628).

# Nebraska FY2004 Community Mental Health Services Block Grant Application

## **ADULT PLAN**

### **Section II – Adult State Plan Context**

#### Adult Goals

- A. State public mental health service system as it is envisioned for the future
- B. Previous State plan
- C. New developments and issues

### **SECTION II – ADULT STATE PLAN CONTEXT /**

#### **ADULT GOAL #1: STRATEGIC PLANNING**

#### **ADULT GOAL #2: CONTINUE TO IMPROVE QUALITY, DELIVERY OF SERVICES AND CONSUMER ACCESS**

#### **ADULT GOAL #3: EMPOWER CONSUMERS**

#### **ADULT GOAL #4: SUICIDE PREVENTION INITIATIVE**

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### **ADULT GOAL #1: STRATEGIC PLANNING**

#### **A. State service system as envisioned for the future**

Consistent with the Governor's priority on mental health and LB 724, implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.

#### **B. Previous State plan**

ADULT GOAL #1: STRATEGIC PLANNING - Implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.

#### **C. New developments and issues**

As noted in Section II – D (Legislative initiatives), the "Nebraska Behavioral Health Reform Act" (LB724) was approved by the Governor on May 13, 2003.

As noted in Section II - F (Leadership), the Lincoln Journal Star (June 9, 2003) reported that Governor Mike Johanns said, if he was forced to pick just one area he could influence during his remaining days as Governor, it would be mental health.

As reported in SECTION III A. (Fiscal Planning Assumptions), the state aid for FY2004 community mental health remained the same as previous fiscal year after the Legislature finished making the massive cuts to the State of Nebraska budget.

As noted in Section II – D (Legislative initiatives), the next indicator of this work, as stated in LB724 Section 9 is for the chairperson of the Legislature's Health and Human Services Committee will prepare and introduce legislation in the next session (2004).

The LB 724 Draft Outline of Implementing Legislation for Behavioral Health System Reform was

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released by Governor Johanns and Senator Jensen on August 20, 2003 at an informal press briefing. Senator Jim Jensen is the Chair, Health and Human Services Committee, Nebraska Legislature.

A brief summary of this includes:

- An initial draft of implementing legislation, based on the outline, is to be completed by 10/1/ 2003.

-- Implementing legislation will be based on the following principles or goals as contained in the draft outline:

1. Providing better services and outcomes for consumers.
2. Strengthening state leadership and accountability within the statewide behavioral health system.
3. Limiting the role of behavioral health regions and regional boards within the system.
4. Closing one or more regional centers (state hospitals for the mentally ill), and reinvesting public and private resources in the development of community-based behavioral health services and in making Nebraska a “center of excellence” for behavioral health treatment, research, and education.
5. Integrating all public behavioral health funding, providing for enhanced utilization of private funds and other public funds, and ensuring the sustainability and appropriate allocation of all behavioral health funding.

-- County Regional Governance System – LB 724 envisions maintaining a regional organizational structure for the delivery of behavioral health services (i.e. the existence of behavioral health regions and regional boards), and preserving local control in each region as much as possible.

-- Regional Centers – This will include one or more sections relating to the role of regional centers (state hospitals for the mentally ill) within the statewide behavioral health system. LB 724 envisions the consolidation and decreased utilization of inpatient regional center services, and the increased development, utilization, and funding of inpatient and outpatient community- based services. The bill intends that one or more regional centers will be closed within the next two years, and that, prior to any such closure, a thorough planning process will be completed and adequate and appropriate community-based service capacity will be developed. LB 724 is based on findings that the continued operation of three regional centers is no longer justified ...

-- Public funding of behavioral health services – LB 724 intends that all public funding for the behavioral health system be integrated and appropriately allocated. The bill envisions the enhanced utilization of private funds and other public funds, including federal funds, for the provision of behavioral health services, with little or no increase in the utilization of state General Funds. LB 724 is based on findings that current behavioral health funding is fragmented by separate administrative and funding mechanisms for inpatient, community-based outpatient, and Medicaid-covered behavioral health services, resulting in higher-cost and potentially less effective treatment for consumers.

## **ADULT GOAL #2: CONTINUE TO IMPROVE QUALITY, DELIVERY OF SERVICES AND CONSUMER ACCESS**

### **A. State service system as envisioned for the future**

Consistent with the Governor's priority on mental health and LB 724, continue to improve consumer access to the services provided by the Nebraska Behavioral Health System (NBHS).

- Improve continuity of care within the requirements of HIPAA
- For persons with serious mental illness, including transitioning young adults, develop coalitions

to promote community based care under Olmstead.

- Housing
- Employment

### **B. Previous State plan**

ADULT GOAL #1: STRATEGIC PLANNING - Implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.

### **C. New developments and issues**

Improving quality, delivery of services and consumer access to the NBHS remains a priority. Many areas need to be addressed. Over the next year, at least three areas will receive attention: continuity of care, housing and employment.

#### CONTINUITY OF CARE

Continuity of Care is intended to ensure coordination of services between community providers. This interaction between authorized providers exists so that a consumer may receive appropriate community mental health and substance abuse services at the proper time.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a complex law involving many different requirements. The Privacy & Security rules are intended to ensure individually identifiable health care information, Protected Health Information (PHI), remains confidential and secure. However, the HIPAA requirements make the exchange of PHI between service providers more challenging.

On the substance abuse side of this are the Federal Regulations 42 CFR Part 2 "Confidentiality of Alcohol and Drug Abuse Patient Records" from the Center for Substance Abuse Treatment (CSAT) are also intended to help protect disclosure of PHI.

The issue is how to coordinate care between authorized mental health and / or substance abuse providers and still meet the requirements of HIPAA.

#### HOUSING

The Statewide Mental Health Housing Coalition was formed between the Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse and Addiction Services and the Nebraska Department of Economic Development (DED) Community and Rural Development Division. Both HHS and DED are committed to the development of housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness.

The long-term goal of this Housing Coalition is to improve the availability of housing for people who are extremely low income with serious mental illness. These mental health housing plans are expected to help address Governor Mike Johanns' expectations to:

1. Decrease the number of post commitment days
2. Decrease the number of Emergency Protective Custody (EPC) situations
3. Decrease the number of days consumers are served in inappropriate levels of care

The HHS and DED co-sponsored the "Nebraska Mental Health Housing Coalition Planning Meeting" held on January 29, 2002.

On May 1, 2002, HHS and DED released the "Mental Health Housing Planner Request For Proposals". Five bids were officially received on June 12, 2002. All five were formally reviewed. As a result of that review, the bid selected was submitted by HANNA:KEELAN ASSOCIATES, P.C., Lincoln, NE (Project #1 \$68,500; Project #2 \$54,200; TOTAL \$122,700)

The HHS and HANNA:KEELAN ASSOCIATES, P.C. have signed the contract to implement these projects. Ron Ross, Director of the Nebraska Department of Health and Human Services, signed the contract on November 27, 2002. The total contract is for \$122,700. The funding sources for the contract are:

- \$10,000 from the Federal Center for Mental Health Services State Coalition Building funds for this contract.
- \$112,700 of HOME (federal) funds through the Nebraska Department of Economic Development, Community and Rural Development Division.

The contract with Hanna:Keelan Associates, P.C., Lincoln, NE is to complete planning to focus on people who are extremely low income with serious mental illness needing housing. There are two projects covered in the contract:

- Project #1 statewide consumer housing need study (draft July 24, 2003) and
- Project #2- planning in four communities Omaha, Lincoln, the Norfolk Area & Tri-City Area (Hastings, Grand Island, and Kearney) (in process).

MENTAL HEALTH HOUSING PLANNING STEERING COMMITTEE - Purpose Of Committee: Develop by December 2003, plans that will focus on people who are extremely low income with serious mental illness needing housing. To accomplish this, the Steering Committee:

- participates in the mental health housing planning work performed by Hanna:Keelan Associates and
- provide their assessment on the overall housing needs for persons who are extremely low income with serious mental illness statewide based on their participation in the study.

Membership of the Mental Health Housing Planning Steering Committee includes: HHS State Long-Term Care Ombudsman, Department of Economic Development, U.S. Department of Housing and Urban Development (HUD), Nebraska Investment Finance Authority, Regional Governing Boards, Mental Health Associations of Nebraska, National Alliance for the Mentally Ill – Nebraska (NAMI-NE) and members of the Nebraska Mental Health Planning and Evaluation Council.

STATEWIDE HOUSING MEETING - HHS is sponsoring the Nebraska Mental Health Housing Summit on November 19, 2003. HHS will sponsor this statewide mental health housing meeting to publicly share the findings from Projects #1 and #2. The funds for this meeting are from the Federal Center for Mental Health Services State Coalition Building (Olmstead) grant.

## EMPLOYMENT

As noted in SECTION III. A. Fiscal Planning Assumptions for Adults and Children the State community mental funds are used to match federal funds from Department of Education Division of Vocational Rehabilitation through a State Cooperative Agreement. Approximately \$1.6 million is devoted to these employment services yearly using a 21% State to 79% federal match rate to serve persons with mental illness in vocational rehabilitation services.

For the last few years, employment issues for individuals with a serious mental illness were being addressed under a project called "EMPLOYMENT 2003". In June 2001, Nebraska officially expanded the "Coalition to Promote Community Based Care Under Olmstead" proposal to include housing, employment, and related issues. George Hanigan, HHS Deputy Director for Behavioral Health (SMHA Commissioner) requested this expansion. The coalition structure Nebraska used was flexible in order to include stakeholders as appropriate for the issues being addressed.

On November 13, 2001, the Employment 2003 Steering Committee submitted to the State Mental Health Planning and Evaluation Council (MHPEC) a report of recommendations for increasing employment opportunities for people with mental illness. The report was also submitted to state vocational rehabilitation, state mental health, and other key stakeholders.

One of the recommendations for enhancing employment opportunities for people with mental illness involved providing opportunities to help local providers network in a forum focused on these issues. The funds for these forums were from the Federal Center for Mental Health Services State Coalition Building (Olmstead) grant.

The agenda for the employment forums included discussions on vocational rehabilitation, social security, benefits analysis, successful employment opportunities, and related topics. Two employment forums were held:

- The Kearney Employment Forum was held on October 8, 2002. 43 people attended.
- The Omaha Employment Forum was held on February 28, 2003. 65 people attended.

In March 2003, the HHS staff member working on these employment issues resigned to take another position. As a result, it was appropriate to take some time to discuss the next steps on this project. That discussion was held at the June 12, 2003 Mental Health Planning and Evaluation Council meeting. After the discussion, a motion that was passed (vote 19 Yes / 0 No) which said:

"The MHPEC asked Ron Ross to support and approve a permanent sub-committee that would play a pivotal role in helping to plan, implement, monitor, and advocate for effective employment services for individuals with psychiatric disabilities."

It was approached in this manner because Nebraska Statute for the Nebraska Mental Health Planning and Evaluation Council [§71-5008.(4)] requirements include the following statement:

"Upon receiving the written approval of the Director of Health and Human Services, the chairperson may appoint and utilize a task force of council members and nonmembers to report to the council on specific areas."

At the same meeting, it was discussed that additional employment forums should be held. HHS and VR will explore ways to hold additional employment forums. At the time of this writing, plans are being discussed to hold two additional, starting with Norfolk, NE.

### **FY2003 ADULT GOAL #3: EMPOWER CONSUMERS**

#### **A. State service system as envisioned for the future**

Continue Development of the HHS Consumer Liaisons as State Leaders to help empower consumers to work As Change Agents and Advocates.

## **B. Previous State plan**

Adult Goal #2: Continue Development of the HHS Consumer Liaisons as State Leaders to help empower consumers to work As Change Agents and Advocates.

## **C. New developments and issues**

The Office of Mental Health, Substance Abuse and Addiction Services has two full-time Consumer Liaisons on staff, Dan Powers and Phyllis McCaul. Overall, the consumer liaisons continue working as change agents and advocates as staff members within the Office of Mental Health, Substance Abuse and Addiction Services. Their leadership both within the Office and in community settings changes the dynamics of a meeting, with consumer concerns being addressed more consistently.

### **FUNDING:**

The Office of Mental Health, Substance Abuse and Addiction Services allocates **\$337,604** annually on consumer empowerment oriented activities. In FY2003, this includes:

- The primary funding source for the consumer liaisons is the five percent (5%) state administrative portion of the Community Mental Health Services (CMHS) Block Grant. In FY2003, this allocation is **\$102,104**.
- State Consumer Initiatives
  - (1) National Alliance for the Mentally Ill –Nebraska (**\$45,750**): The Office contracts with the National Alliance for the Mentally Ill -Nebraska to ensure a state organizational structure is available for consumers. This contract provides support for the development of infrastructure for mental health education, support and advocacy.
  - (2) League of Human Dignity (**\$10,000**): This contract is used to fund cash advances and reimbursements to consumers in order to help people attend meetings, workgroups and conferences.
  - (3) Mental Health Association of Nebraska(**\$45,750**). The Office plans to contract with the Mental Health Association to train people to work as advocates in Nursing homes and assisted living facilities.
- Peer Specialists

With the FY2000 Federal Community Mental Health Block Grant increase, the Office started funding two (2) Peer Specialist positions (**\$60,000**) in Day Support.

WEB SITE: The Nebraska Department of Health and Human Services web site provides a summary on how to contact the Consumer Liaisons. Go to the HHS web site and click on "Behavioral Health". <http://www.hhs.state.ne.us/beh/behindex.htm>

- Click on: Citizen Advocacy and Planning Groups
- Click on: Mental Health Consumer Advocacy
- You will arrive at <<http://www.hhs.state.ne.us/beh/mh/mhadvo.htm>>

On the “Mental Health Consumer Advocacy” web site there are links to national and state mental health advocacy groups:

- National Alliance for the Mentally Ill
- National Alliance for the Mentally Ill – Nebraska
- National Mental Health Association
- Mental Health Association of Nebraska

## AREAS OF WORK

There are a number of areas the two Consumer Liaisons address, including:

- **Mental Health Consumer Advocacy**

Those individuals who are experiencing difficulty with Nebraska's mental health system are encouraged to contact either Dan Powers or Phyllis McCaul (call 1-800-836-7660 or e-mail).

- **Annual Consumer Conference**

Annually the Office funds a consumer conference designed to educate consumers in mental health issues and to speak up to national, state and local mental health officials to advocate on their and the systems behalf. The consumer liaisons facilitate the planning and implementation for the Consumer Conference. This year the 2003 Mental Health Consumer Conference will be held on September 23-25, 2003 in Aurora, NE. Mary Ellen Copeland is the featured speaker. The Governor has expressed an interest in making a brief presentation. (The Governor has identified Mental Health as his number one priority this year.) Information is posted on the Behavioral Health Web site.

The consumers participating in this annual conference come from all across the state. In order to participate, a consumer completes an application form and sends it to HHS. As of August 8, 2003, there are 199 people who have submitted an application. The order of selection is: (1) those who have not attended the conference before, (2) represent a minority or ethnically diverse group, (3) least number of times attending a conference with consideration for geographic distribution. (4) willingness to attend and participate in conference based on information in application. Due to the budget constraints, the conference participants will be limited to 100 individual consumers.

Included in the 100 participants are "Conference Guides". These consumers are expected to serve in a leadership role during this annual conference. In order to be considered for this role, the individual needs to have (1) attended the conference before, and (2) received leadership training.

The "Conference Guides" duties include a number of different roles. One role is to help participants find their way around the conference. For example, helping a first time participant to decide which event to attend.

A second function is to serve as a role model in sharing the results from this conference with other consumers. Here, some of the Conference Guides serve as group facilitators. Conference participants are divided into groups of about 10-20 participants. Within each group, participants have the opportunity to share ideas and thoughts on what has been learned during the conference. A group spokesperson, other than the Conference Guide, gives a report to the all conference participants on the last day. This is usually followed by an open microphone where consumer participants can, and do, say anything they want to the group.

- **Advisors on HHS Community Mental Health Policy**

The consumer liaisons routinely participate in HHS Community Mental Health policy development. Examples include:

- (1) Attend the monthly Network Management Team meetings.
- (2) Attend the NMT/CEO Transition Training Planning Team.
- (3) Advise the Legislature on the amendment of Mental Health Commitment Statutes and changes in the mental health system

The monthly Network Management Team meeting is important to the delivery of services to consumers. At the Network Management meeting HHS staff and Regional Program Administrators discuss implementation of contracts for the delivery of services and other issues including planning for long term goals.

- Peer Specialists

With the FY2000 Federal Community Mental Health Block Grant increase, the Office started funding two (2) Peer Specialist positions (\$60,000) in Day Support. The two Peer Specialist positions funded were:

- ✓ Cirrus House, Scottsbluff (Region 1)
- ✓ Central Nebraska Goodwill, Grand Island (Region 3)

The term “Peer Specialist” was defined as “a person who is a consumer with a history of meeting the SMI criteria, however, has been in recovery to the point of being able to hold down a job, lives independently, and other related signs of functional stability.”

- Consumer/Survivor Mental Health Administrators

Participate in activities and meetings with the National Association of Consumer/Survivor Mental Health Administrators. One of the consumer liaisons is President of the National Association of Consumer Survivor Mental Health Administrators and was involved in preparation of "A Roadmap to a Restraint Free Environment for Persons of All Ages". Plans are being made to pilot this manual in two facilities. As President of NAC/SMHA he attended the National Association of Mental Health Program Directors Winter Meeting in Fort Lauderdale and the Summer Meeting in Sand Diego. At the Summer Meeting he was given the Commissioner’s proxy and represented the State of Nebraska also. The Association held a Retreat in Boston in October 2002 and is holding training in St. Louis in September 2003. As President he was invited to attend a block grant peer review as an observer to the southeastern region peer review in Arlington, Virginia November 29-21, 2002. As President he was invited to comment at the National Call to Action: Elimination of Restraint and Seclusion held May 5, 2003 in Washington DC. He strongly supported the elimination of Restraint and Seclusion and thanked Charles Curie for his leadership in this area.

- Co-Coordinate the annual Board of Mental Health Training

One of the Consumer Liaison co-coordinates the training of the Boards of Mental Health. This Mental Health Board Training is a requirement of the Mental Health Commitment Act [Neb. Rev. Stat. § 83-1018 (4)]. For more information on this work, see Criteria 5.

- Substance Abuse Consumers

A new initiative is the development of Substance Abuse Consumers to be advocates. The consumer liaisons are working with several substance abuse providers on establishing the Nebraska Recovery Network. The purpose of this network is (1) to provide the recovering community and its allies with a public voice to communicate their unique perspective and (2) to provide insight about the disease of addiction and the road to recovery." It is planned to use \$14,000 of State Substance Abuse funds to help build the Nebraska Recovery Network.

- Consumer Satisfaction Program Visits

The consumer liaisons complete “Consumer Satisfaction Program Visits” to programs throughout the State. A Consumer Liaison does four or more community program site visits monthly. Each program visit results in a report given to HHS staff, Regional Program Administrator for that area, and the director of the program. The report covers the consumer liaison’s observations and opinions; as well as the aggregated results from the question survey with consumers. The question in this

survey are usually handled in a face-to-face interview. Usually 5 face-to-face surveys are completed. Some locations distribute the questions in a written form for consumers to complete.

Phyllis McCaul, Consumer Liaison, revised (as of August 5, 2003) the questions for Consumers Satisfaction Visits. It starts with noting the Name of Program / Date / Type of Program. Then she asks the questions listed below:

Group 1: Access to Health Care

Doctor

- a. Do you have a physical health care doctor? Yes or No
- b. If no then why?
- c. Do you know the name of your doctor? Yes or No
- d. When was the last time you visited him/her?
- e. Did the program help you find your doctor? Yes or No

Dentist

- a. Do you have a Dentist? Yes or No
- b. If no then why?
- c. Do you know the name of your dentist? Yes or No
- d. When was the last time you visited him/her?
- e. Did the program help you find your dentist? Yes or No

Vision

- a. Have you had your vision checked? Yes or No
- b. If no, then why?
- c. When was the last time you had your vision checked?
- d. Where did you go to do this?
- e. Did the program help you find this place? Yes or No

Psychiatrist

- a. Do you have a psychiatrist? Yes or No
- b. If no, then why?
- c. Do you know the name of your psychiatrist? Yes or No
- d. When was the last time you visited him/her?
- e. Did the program help you find your psychiatrist? Yes or No

Group 2.

1. a. Would you rate this program as: Excellent, Good, Fair, Poor, Don't know  
b. Why do you feel this way?
2. What are your plans for the future?
3. Do you feel that the staffs at this program respect you?
4. What do you think would help you in this program?
5. How long have you been in this program?
6. a. Were you involved in developing your rehab goals?  
b. If so, was your input taken into consideration and did it become part of the goals.
7. Are you making progress to complete your goals?
8. a. How often are your rehab goals updated?  
b. Are your ideas put into those goals?

Other Comments:

- Consumer Mailing List

The liaisons have developed and maintained a list of interested people to receive mailings on consumer oriented topics. This list is also used as a source of information on individuals who may

be interested in working on state or regional advisory or strategic planning groups. Most of the names on this mailing list are collected during the Consumer Satisfaction Program Visits’.

- **Liaison to the Mental Health Association**

The Mental Health Association – Nebraska reaches a lot of consumers. One project will involve one of the consumer liaisons to work in coordination with the HHS State Long-Term Care Ombudsman and Mental Health Association to make quality changes in all of the Assisted Living Facilities (ALF) licensed in Nebraska who are serving residents who are mentally ill.

## **ADULT GOAL #4: SUICIDE PREVENTION INITIATIVE**

### **A. State service system as envisioned for the future**

Continue Development of Statewide Suicide Prevention Initiative

### **B. Previous State plan**

Adult Goal #3: Continue Development of Statewide Suicide Prevention Initiative

### **C. New developments and issues**

Members of the Statewide Suicide Prevention Initiative committee worked in collaboration to submit a grant to Nebraska Health Care Council (overseeing the tobacco money in HHS). The Nebraska Health Care Cash Fund Grant award was for a total of \$125,000.

- Year one started October 1, 2001 and is for \$75,000.
- Year two ends September 30, 2003 and is for \$50,000.

Blue Valley Mental Health Center in Beatrice NE is the grant recipient, in collaboration with the Community Mental Health Center of Lancaster County (CMHC) and BryanLGH Medical Center in Lincoln.

Overall, the grant was intended to help develop local expertise in suicide Prevention. Curricula was developed in year one and tested in year two. The final product was a public domain curriculum in suicide prevention designed for delivery via a train the trainers model. This model develops and maintains local expertise in suicide prevention. The curriculum will soon be made available for download from a web site.

The target population for this pilot was adults in Southeast Nebraska with emphasis on reaching those at highest risk for suicide. The major goals of the project include:

1. Increase awareness of warning signs, risk factors, and interventions to prevent suicide.
2. Reduce stigma surrounding suicide and seeking help.
3. Positively influence a reduction of the suicide rate in southeast Nebraska.

Here is a brief summary of suicide prevention activities as of July 28, 2003.

- The Nebraska State Suicide Prevention Work Group has met quarterly. This is an open group with a core membership. It is unfounded but includes representatives from government, Universities, Corrections, Survivors, Law Enforcement, Human Service Agencies, and Faith-based groups.
- The state work to date was presented at the American Association of Suicidology in April, 2002 and April, 2003.
- An update on the state suicide prevention activities was given at the Mental Health Planning & Evaluation Council meeting on June 12, 2003

- The core curriculum and the four specialty modules have been developed and tested. The four specialized areas are:
  - **Law Enforcement** – this module has been adopted by the State Law Enforcement Training Academy in Grand Island and the Police Department in Lincoln, Nebraska as official curriculum for recruit training.
  - **Primary Care Providers** – The core curriculum and healthcare module has been made into a video for distribution and use by BryanLGH Medical Center in Lincoln and within the Heartland Health Alliance (a consortium of Hospitals throughout Southeast Nebraska.) BryanLGH has made the curriculum part of required training for medical center staff on both campuses in the city.
  - **Educators** – This module has been introduced to educators in several Southeast Nebraska communities as well as the School and Community Substance Abuse Intervention Teams.
  - **Faith-Based Workers** – Clergy and faith-based workers around Southeast Nebraska have participated in both the core training and the specialized faith based module. This module has been used to pilot eulogy recommendations for the Suicide Prevention Resource Center that serves as a national technical assistance provider to states in the area of suicide prevention planning and implementation.

What's next?

1. Year two funding for the Southeast Suicide Prevention Project ends September 30, 2003. They are seeking funding to evaluate the effectiveness of this gatekeeper training.
2. The State Suicide Prevention Work Group will continue to support the evaluation and dissemination of gatekeeper training while working to update the Nebraska State Plan for Suicide Prevention.
3. Representatives from the State Work Group are planning to attend a multi-state planning and education conference sponsored by the Suicide Prevention Resource Center in October 2003.
4. The State Work Group will work toward furthering awareness, intervention, and methodology through networking and integration of activities with existing resources, projects, and venues as the amount of funding dedicated to suicide prevention from the state is expected to remain flat.

## **ADULTS WITH SERIOUS MENTAL ILLNESS**

### **CRITERIA 1, 2, 4, AND 5 ARE ADDRESSED**

**Criterion 1:** Comprehensive Community- based Mental Health Service Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services, and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services
  - Housing Services
  - Educational Services

- Substance Abuse Services
- Medical and dental services
- Support services
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services; and
- Other activities leading to reduction of hospitalization.

### **Organizational Structure for the System of Care:**

The Nebraska Comprehensive Community Mental Health Services Act (Neb. Rev. Stat. §§ 71-5001 - 71-5015), established the framework for the provision of behavioral health services in Nebraska. One of the primary goals of the Act was to ensure that all Nebraskans have access to a comprehensive system of community-based behavioral health services. As provided in the Act, the Nebraska **mental health** system was organized into six service delivery areas governed by regional governing boards that are responsible for directly delivering and/or contracting for services with providers. State and federal community mental health funds are allocated to the regional governing boards by contract for service delivery at the local level. The regional governing boards contract with public and/or private service agencies or individuals to provide services in their regions or assume direct responsibility for the provision of community-based services.

At the State level, the Act designates the Department of Health and Human Services as the agency responsible for leadership, planning, and coordination of mental health services in Nebraska. To carry out that responsibility, the Department administers state and federal mental health funding, contracts with the regional governing boards for services, oversees planning, and monitors the provision of mental health services. A further description of the State's community-based system of care is provided in Section II of this application.

### **A description of health medical, dental, employment and educational services that support adults with SMI in the community.**

In order to enable individuals with Serious Mental Illness (SMI) to function outside of inpatient or residential institutions to the maximum extent of their capabilities, the "Community Support Mental Health" service provides linkages, referrals and coordination of necessary services and supports as identified in the Individual Service Plan (ISP) to ensure consumer recovery, including, but not limited to: **rehabilitation services; employment services; housing services;** (Residential and Transitional Residential), **educational services; substance abuse services; medical and dental services; support services; case management services;** and other activities to help reduce psychiatric hospitalization.

The Office of Mental Health, Substance Abuse and Addiction Services has the responsibility to ensure that the community mental health, substance abuse, and gambling assistance services needed by Nebraskans are available and accessible in Nebraska. Here is an overview:

- The General Mental Health Services array includes specialized mental health treatment services that have a primary acute care mission. The main focus of these services is appropriate diagnosis and the amelioration of symptoms through effective treatment. For the most part, mental health services delivered through these service options are short-term and time-limited.
- The Psychiatric Rehabilitation and Support array is composed of specialized mental health services that have a primary psychiatric rehabilitation and support mission. Here the main focus shifts from illness to disability with the goal of providing the support necessary for the individual to live in the least restrictive setting. These services also focus on rehabilitative interventions

that allow the consumer to overcome or maximally compensate for the deficits produced by mental illness. The Psychiatric Rehabilitation and Support Array, in contrast to the General Mental Health Services array, is composed of long-term services that assume the need for consistent (at least once per week) involvement with one or more of the Rehabilitation and Support services over a long period of time (months or years).

### **Description and Definition of the State's Case Management System:**

In Nebraska, case management services are part of the service referred to as “Community Support”. A description of the Community Support Mental Health-Adult is

1. The Mental Health Community Support program is for persons disabled by severe and persistent mental illness.
2. This service is designed to provide direct face to face contact with consumers to develop skills necessary to live as independent a life in the community as the consumer is able.
3. Emphasis is on an active rehabilitation plan addressing all functional deficits.
4. Ancillary services include **case management** and advocacy.

Please note item 4 includes **case management**. Items 1-3 go far beyond that.

The service is provided to adults with serious mental illness in need of intensive in-home and in-community services. The intent of the service is to increase independent living skills, enhance quality of life, and decrease the frequency and duration of hospitalization by linking the consumer to appropriate service providers, providing rehabilitative/support services and monitoring service provision of other allied service providers. Community Support occurs on an ongoing basis at the individual's place of residence or other locations as specified in the consumers Individual Service Plan (ISP). The community support program provides a clear focus of accountability for meeting the consumer's needs within the resources available in the community. The role(s) of the community support provider may vary based on consumer's needs. Community support is an in-vivo service with most contacts typically occurring outside the program office i.e., in the consumer's place of residence or other community locations consistent with individual consumer choice/need. The contact frequency is individualized and adjusted in accordance with the level of rehabilitation and support needed by the individual.

### **Services For Individuals Diagnosed with Both Mental Illness and Substance Abuse**

One expectation of Behavioral Health providers in Nebraska is that they should have arrangements to assess the need for mental health and substance abuse services among clients of the agency. Upon recognition, the provider makes suitable arrangements available to the client either through referral or as a part of the program activities. An ongoing requirement in service definitions since 1998 includes all of primary mental health treatment services screen for substance abuse and seek consultation for further evaluation. All of the primary substance abuse treatment services screen for mental illness and seek consultation for further evaluation.

Official state definitions on services for individuals diagnosed with both mental illness and substance abuse include:

- (a) Dual Disorder: an adult with a primary severe and persistent mental illness AND a primary chemical dependency disorder. An adolescent with a primary severe emotional disturbance and a primary chemical dependency (or diagnosed entrenched dependency pattern).
- (b) Dual Disorder Treatment: dual disorder services provide primary integrated treatment simultaneously to persons with an Axis I chemical dependency AND an Axis I major mental illness. Clients serviced exhibit more unstable or disabling co-occurring substance dependence and serious and persistent mental illness disorders. The typical client is unstable or disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in addictions treatment. Providers of Dual

disorder treatment programs demonstrate a philosophy of integrate treatment in treatment plans, program plans, staffing, and services provided. Both disorders are treated as equally primary. Appropriate licensed and certified staff including staff with addiction certification is required to provide treatment.

- (c) **Dual Enhanced Treatment:** a service for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers of these treatment services may elect to enhance their primary service to address the client's other relative stable diagnostic or sub-diagnostic co-occurring disorder. The primary focus of such programs is mental health or addictions treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

A new Dual Disorder Treatment program that meets this state definition for dual treatment was developed in Region 4 in early 2002 with the new/expanded tobacco funds. The Well Link in Norfolk just developed a Dual Residential program for women with SPMI and CD only and is funded with both MH Tobacco funds and SA Tobacco funds.

#### Fee-For-Service or Non-Fee

Nebraska pays public providers either on a fee-for-service or non-fee basis.

- **Register** – Non-fee basis is an expense reimbursement system. Agencies are paid up to a maximum stated in a contract for the purpose of operating a program or service type.
- **Authorize** – Fee-for-service is Nebraska's managed care system and is a payment system based on units of service.

Units are paid for a person and are based on fees set by the State, or Regional Governing Board and the private non-profit entity providing the service. An individual receiving services paid for on a fee-for-service basis, must have the service authorized by Magellan Behavioral Health Care, Inc. -- The Nebraska public, community-based system, managed care administrative service organization. The tables below provide a listing of the Nebraska behavioral health service names. For more information see: <<http://www.hhs.state.ne.us/beh/bhsvcdef.htm>>

Adult Behavioral Health Service Definitions are located on the HHSS web site at:

<http://www.hhs.state.ne.us/beh/bhsvcdef.htm>

The tables below provide a listing of the Nebraska behavioral health service names. The definitions are available in the Service Definitions document at:

<http://www.hhs.state.ne.us/beh/ServiceDefs3-03.pdf>

#### Nebraska Behavioral Health System Service Definitions

Community Support MH (Adult) .....	page 11
Day Rehabilitation .....	page 13
Intermediate Residential .....	page 16
Medication Management .....	page 17
Psychiatric Residential Rehabilitation	page 18

Cornerstone Services		Authorize	Register
<b><i>Emergency Services</i></b>			
	24 hour Clinician on-call / phone		X
	Crisis Assessment/Evaluation		X
	Mobile Crisis Intervention		X

	Emergency Shelter –Social Detox		X
	Emergency Shelter –Psych Respite		X
	Emergency Community Support		X
	Emergency Protective Custody		X
	Civil Protective Custody		X
	Emergency Shelter –Residential Stabilization		X
<b><i>Community Support</i></b>			
	Mental Health	X	
	Substance Abuse	X	
	Assertive Community Treatment (ACT)	X	
<b><i>Prevention Strategies</i></b>			
	Information Dissemination		X
	Prevention Education		X
	Alternatives		X
	Problem Identification/Referral		X
	Community Based		X
	Environmental		X

<b>Levels of Care</b>		<b>Authorize</b>	<b>Register</b>
<b><i>Inpatient</i></b>			
	Acute Inpatient	X	
<b><i>Residential</i></b>			
	Secure Residential – MH	X	
	Intermediate Residential – MH	X	
	Intermediate Residential – SA	X	
<b><i>Transitional Residential</i></b>			
	Psych Residential Rehabilitation – MH	X	
	Short-Term Residential – SA	X	
	Halfway House – SA	X	
	Dual Residential	X	
	Therapeutic Community – SA	X	
<b><i>Non-Residential</i></b>			
Level 1	Day Treatment – MH	X	
	Partial Care – SA	X	
Level 2	Intensive Outpatient – MH	X	
	Intensive Outpatient – SA	X	
Level 3	Day Rehabilitation – MH	X	
	Vocational Rehabilitation	X	
Level 4	Outpatient Assessment/Therapy – MH		X
	Outpatient Assessment/Therapy – SA		X
	Psychological Testing		X
	Medication Management – MH		X
	Medication Management – SA Methadone		X

Level 5	Day Support		X
	Vocational Support – MH		X

### REGIONAL CENTER CAPACITY

Here is the capacity of the three Nebraska Regional Centers (state psychiatric hospitals) as of July 24, 2002 and as reported in the Lincoln Journal Star, July 28, 2003 (The three regional centers have a capacity for 591 patients: 261 at Lincoln, 174 at Norfolk and 156 at Hastings).

#### LINCOLN REGIONAL CENTER (Lincoln NE)

Adult Psychiatric Inpatient Programs	Beds	
Short Term Care Program	43	
Community Transition Program	40	
Forensic Mental Health Service	43	
Male sex offender	64	
Male sex offender transition program	16	
Female locked program: sex offender, forensic program, and aftercare groups	5	
Adolescent and Family Services		
Acute Inpatient Psychiatric Program	6	
Residential Psychiatric Program	20	
Facility Beds		237
Adolescent White Hall Residential Campus (Sex Offender)		
Warner House	8	
Community Life	8	
Family Life (opens September 2002)	8	
Total Beds (Facility & Community)		261

Non-Residential Mental Health / Outpatient Services
Adolescent competency evaluation services (12 per year estimated)
Adult Aftercare Sex Offender Services – 24 patients enrolled
Adult Psychiatric Forensic Evaluations – 20 evaluations annually
Adult Community Transition Program Outpatient Visits / 15 minute medication check – by LRC Psychiatrist 119 visits annually
Wagon Wheel Industrial Center (used by inpatient & outpatient) 18 average daily census
LB95 patients / outpatient services, about 170 patients.
Short Term Care Outpatient Dual Diagnosis Program (may open in September 2002) is being designed as a bridge between LRC and community placement/services.

#### NORFOLK REGIONAL CENTER (Norfolk, NE)

Adult Psychiatric Unit	Beds	
Secure Acute Inpatient Mental Health (3 west)	36	
Secure Residential Mental Health – Male Only (2 East)	35	
Secure Residential Mental Health – Mixed (3 East)	35	
Secure Intermediate Mental Health (2 west)	35	
Secure Adult / Neuro-geriatric unit (1 west)	33	
Total Beds / Adult Psychiatric Unit		174

Non-Residential Mental Health
Day Treatment / Partial Hospitalization Average Daily Census = 10
Out-patient / Medication Management – total of 160 patients. -- 80 patients in the outpatient program -- 80 patients in the LB 95 program for a Note: Some of the patients may be in both programs but are only registered in one or the other because the AIMS system can only have a patient in one program at a time.

#### HASTINGS REGIONAL CENTER (Hastings, NE)

Service/Program	Beds
Ward 33 Acute/Secure Male	28
Ward 34 Acute/Secure Female	28
Ward 30 Secure Sex Offender	14
Ward 36 Acute Long Term Adult	28
Ward 37 Adult Residential	28
Adolescent Substance Abuse	30
Total	156

Non-Residential Mental Health / Outpatient Services
ACT - 59 clients currently served – capacity of 72
52 clients are being served by Outreach staff - this service will in the future just be called Outpatient Services (formerly the Neuro-geriatric Outreach)
Day Treatment service is currently serving 5 clients – HRC plans to discontinue this service.
Medication Management – 139 clients

#### FY 2004 Nebraska MENTAL HEALTH PLAN

##### Criterion 1: Comprehensive Community- based Mental Health Service Systems

**GOAL:** Maintain capacity of Community Support Services

**OBJECTIVE:** In light of current state budget, by June 30, 2003, the number of persons served with Serious Mental Illness receiving Mental Health Community Support Services will remain at current capacity (as of July 2003, there are about 2,450 slots of Community Support services).

##### POPULATION: SMI Adults

Performance Indicator (1)	FY2002 Actual	FY2003 Actual	FY2004 Objective	% Attained
Value:	2,607	2,613	2,600	

**Number of persons SMI who are receiving Mental Health Community Support (including case management) services**

Value = all persons reported SMI receiving Mental Health Community Support

Data source: from Magellan Behavioral Health Information System, as under contract with NE HHS/ Office of Mental Health, Substance Abuse, and Addiction Services.

**Criterion 2: Mental Health System Data Epidemiology**

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and **(based on old Criterion 11)**
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion one (1). **(based on old Criterion 2).**

**CENSUS DATA**

According to the web site < <http://www.census.gov/>> the U.S. Commerce Department's Census Bureau provides the Nebraska demographic data from the Census 2000. Nebraska ranks number 38 in population of the United States, with 0.6% to the total. While the US population grew by 13.2%, Nebraska's grew by 8.4%.

	April 1, 2000		1990-2000	1990-2000	
	Population	State rank	Numeric change	Percent change	% of Total
<b>United States</b>	<b>281,421,906</b>		<b>32,712,033</b>	<b>13.2</b>	<b>100%</b>
<b>Nebraska</b>	<b>1,711,263</b>	<b>38</b>	<b>132,878</b>	<b>8.4</b>	<b>0.61%</b>

**Nebraska Statewide by Race**

<b>Total</b>	<b>White</b>	<b>Black</b>	<b>American Indian, Eskimo or Aleut</b>	<b>Asian or Pacific Islander</b>	<b>Hispanic Origin <sup>1</sup></b>	<b>Other Races <sup>2</sup></b>
1,711,263	1,533,261	68,541	14,896	22,767	94,425	71,798
100.0%	89.6%	4.0%	0.9%	1.3%	5.5%	4.2%

**Nebraska Statewide by Sex**

Male	843,351	49%
Female	867,912	51%
<b>TOTAL</b>	<b>1,711,263</b>	<b>100%</b>

Source: Nebraska Databook, Last Updated on 5/21/01 <http://info.neded.org/stathand/bsect8.htm> based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001.

**Metropolitan Statistical Areas (MSA) 50,000 or more**

In Nebraska there are six counties designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. These counties are

Region VI – Douglas (includes City of Omaha / 390,007), Sarpy, Cass, Washington,

Region V – Lancaster (includes City of Lincoln / 225,581),

Region IV – Dakota county (includes South Sioux City / 11,925) connected to Sioux City, Iowa.

SARPY County includes Offutt Air Force Base in the Omaha, NE—IA MSA.

More than half of Nebraska's population now lives in metropolitan areas. As of 2000, the Nebraska portion of the "Omaha, NE—IA MSA" (Cass, Douglas, Sarpy, and Washington Counties) is 629,294 people. The "Lincoln, NE MSA" (Lancaster County) has 250,291. These two MSAs have 879,585 people accounting for 51.4% of the state population.

The Nebraska portion of the "Sioux City, IA—NE MSA" (Dakota County, NE) has 20,253 people. When combined with the other two MSAs in Nebraska, there is a total of 899,838 people accounting for 52.6% of the 1,711,263.

### **Micropolitan Statistical Areas 10,000 to 49,999**

The COUNTY is in CAPS; the Core Based Statistical Area Population of 10,000 to 49,999 is noted as the "city" within the county listed.

- Region I has SCOTTS BLUFF (36,951) with the Scottsbluff / Gering Area (23,129) consisting of the cities of Scottsbluff (14,732), Gering (7,751), and Terrytown (646)..
- Region II has LINCOLN (34,632) with the City of North Platte (23,878) and DAWSON (24,365) with the City of Lexington (10,011)
- Region III has HALL (53,534) with the City of Grand Island (42,940); BUFFALO (42,259) with the City of Kearney (27,431); and ADAMS (31,151) with the City of Hastings (24,064).
- Region IV has MADISON (35,226) with the City of Norfolk (23,516); PLATTE (31,662) with the City of Columbus (20,971);
- Region V has GAGE (22,993) with the City of Beatrice (12,496)
- Region VI has DODGE (36,160) with the City of Fremont (25,174)

### **Rural and Frontier areas**

On the other end of things would be the Frontier area concept. According to Rural Policy Research Institute (University of Missouri, Columbia, MO) the term "Frontier Area" is used to describe an area with extremely low population density. Frontier Areas are isolated rural areas characterized by considerable distances from central places, poor access to market areas, and people's relative isolation from each other in large geographic areas.

The National Rural Institute on Alcohol and Drug Abuse uses the following definitions of "Rural"

- Rural areas contain 50 or fewer people per square mile
- Frontier areas contain 6 or fewer people per square mile.

Overall, Nebraska has 22.3 Persons Per Square Mile.

Applying these standards to Nebraska's "Population Density By County" shows:

- 52 – Rural counties (604,757 population; 35% total population / areas containing 50 or fewer people per square mile)
- 33 – Frontier Counties (93,711 population; 5% total population / areas contain 6 or fewer people per square mile).
- 8 – remaining Nebraska Counties (1,012,795 population, 59% total population / with more than 50 people per square mile. The Nebraska Counties with more than 50 people per square mile were Adams, Hall (Region 3), Madison, Dakota (Region 4), Lancaster (Region 5) and Dodge, Sarpy, Douglas (Region 6).

Source: Fact Sheet #1 "Definitions of Rural"

National Rural Institute on Alcohol and Drug Abuse; University of Wisconsin-Stout;  
140 Vocational Rehabilitation Building; P.O. Box 0790; Menomonie, WI 54751-0790

Nebraska has **33 Frontier Area counties**. This includes 11 counties with less than 1,000 people [Keya Paha (983), Wheeler (886), Banner (819), Hooker (783), Logan (774), Grant (747), Thomas (729), Loup (712), Blaine (583), McPherson (533), And Arthur (444)].

The Commerce Department report ranks the nation's 3,110 counties by per-capita income, figured by dividing an individual county's income by its population.

**NOTE:** Seven of the nation's 12 poorest counties in 2001 were in Nebraska.

- **Loup County** ranked #1 as the nation's poorest with a per-capita income of \$6,235.
- #2 and #3 poorest counties were **Blaine** and **Arthur** with per-capita incomes below \$9,000.
- Joining them were the Nebraska counties of **Grant** (ranked seventh-lowest), **McPherson** (at eighth), **Sioux** (ninth) and **Hooker** (12th).

Nationally, the per-capita income figure was \$30,413.

- The Nebraska statewide per-capita income for the same period was \$28,861.
- The U.S. Census Bureau's 2001 poverty guideline for a single person was \$8,590.

All seven of Nebraska's lowest-income counties have several things in common:

- Each rely heavily on the livestock economy
  - Each are in the Sandhills or the Panhandle.
  - All of their economics are in one area -- agriculture.
  - They have among the smallest populations in the state, ranging from 444 people (Arthur) to 1,475 (Sioux).
  - They have at most three towns within their borders. They are not near hub cities or Interstate 80.
- Source: "7 counties rank high in poverty;" / Lincoln Journal Star; Section: Nebraska; June 08, 2003

**NOTE: Cows Outnumber Humans in Nebraska**

The U.S. Census Bureau puts Nebraska's human population at 1.7 million. There are 6.4 million cattle counted in the most recent Nebraska Agricultural Statistics Service livestock census. This means cows outnumber people here nearly 4-to-1. Only six of Nebraska's 93 counties have more people than cattle. Humans outnumber cattle in the metropolitan areas of Omaha (Douglas, Sarpy and Cass counties) and Lincoln (Lancaster county). People also hold a slight edge in northeast Nebraska's Wayne and Dakota counties.

source: Lincoln Journal Star Sunday, June 22, 2003; Section C / NEBRASKA; page 1C and 6C.

**PENETRATION/UTILIZATION RATES**

National Estimated number of Adults in Nebraska with serious mental illness	<b>67,701</b>
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**Number of Persons with Serious Mental Illness (SMI), age 18 and older 2000**

(1) Civilian Population with SMI	(2) Civilian Population	(3) Lower Limit of Estimate	(4) Upper Limit of Estimate
<b>67,701</b>	1,253,717	46,388	89,014

Col 1: Civilian Population with SMI (5.4% of adults age 18+). Civilian population excludes military personnel residing in the geographic area. Rationale is that these personnel are served by the Military or health insurance coverage provided by the military.

Col 2: Civilian Population in 2000

Col 3: Lower Limit of Estimate (5.4% - 1.96(.9)): 95% confidence bound

Col 4: Upper Limit of Estimate (5.4% + 1.96(.9)): 95% confidence bound

Source:

e-mail from "Ronald Manderscheid" <rmanders@samhsa.gov>01/10/03 and 01/15/03

subject: [Data\_Infrastructure\_Grants] Updated Table 1 Information

Information on prevalence estimates for SMI and SED.

U.S. Department of Health & Human Services, Center for Mental Health Services (CMHS)

Number SPMI Served by Region for State FY2002 by Estimated Number of SPMI by Region								
	REGIONS							
	1	2	3	4	5	6	Unknown	Total
Value = Percent Treated FY2002 (of SPMI)	25.7%	24.0%	29.4%	16.6%	25.6%	23.7%		24.3%
Value = Percent Treated FY2002 (of the 7,556)	5.60%	5.92%	15.70%	8.62%	25.41%	37.92%	0.85%	100.00%
Numerator = SPMI Served by Region in FY2002	423	447	1186	651	1920	2865	64	7,556
Adults in NE who have a severe and persistent mental illness (SPMI)	1,645	1,862	4,034	3,910	7,510	12,072	N/A	31,033
Adults in NE who have a serious mental illness (SMI)	3,289	3,724	8,069	7,820	15,020	24,144	N/A	62,066

Nebraska Population by Mental Health Region (Census 2000)							
	1	2	3	4	5	6	State Total
Population age 18 Years & Older / Region Total	66,834	75,661	163,933	158,889	305,167	490,537	1,261,021
Total Region Population	90,410	102,311	223,143	216,388	413,557	665,454	1,711,263
Region % =	5.30%	6.00%	13.00%	12.60%	24.20%	38.90%	100.00%

Data source: HHS Office of Mental Health, Substance Abuse, and Addiction Services.

- Adults in Nebraska have a serious mental illness (SMI) (5.4% of adults)

\*source: Federal Register / Vol. 64, No. 121 / Thursday, June 24, 1999; page 33896

Note: Civilian Population with SMI = 67,701

Civilian population excludes military personnel residing in the geographic area. Rationale is that these personnel are served by the Military or health insurance coverage provided by the military. Source: U.S. Department of Health & Human Services, Center for Mental Health Services January 2003

- AGE: · 18 years & older is 1,261,021; Under 18 years is 450,242; and TOTAL Nebraska Population is 1,711,263. Source: Nebraska Databook, (Last Updated on 5/21/01). Based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001.  
<<http://info.neded.org/stathand/bsect8.htm>>
- AGE: · 18 years & older is 1,261,021; Under 18 years is 450,242; and TOTAL Nebraska Population is 1,711,263. Source: Nebraska Databook, (Last Updated on 5/21/01). Based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001.  
<<http://info.neded.org/stathand/bsect8.htm>>

**Federal Serious Mental Illness (SMI) Criteria** - Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness SMI are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

For the purposes of the Nebraska Mental Health Block Grant reporting the number of persons served who meet this SMI criteria, the following methods were used to operationalize this definition:

**Step 1: a diagnosable mental, behavioral, or emotional disorder**

Diagnosis # 295 - 298.9 [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) © 2000 American Psychiatric Association. Schizophrenia (295), Mood Disorders including Bipolar and Major Depression (296), Delusional Disorder (297.1), Shared Psychotic Disorder (297.3), Brief Psychotic Disorder (298.8), and Psychotic Disorder NOS (298.9) ["Not Otherwise Specified"]. ... and ...

**Step 2: resulted in functional impairment** – The functional impairment component of the SMI designation is addressed by:

- a. SSI/SSDI eligible (include eligible receiving pay, eligible not receiving pay, potential eligible) or
- b. Served in one of the NBHS funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services)
- or
- c. Have an Axis V – Global Assessment of Functioning (GAF) Scale score of less than 60.

Step 1: a **diagnosable** mental, behavioral, or emotional disorder  
[Diagnosis (dx) Only Unduplicated Count (all those with dx 295 – 298.9)]:

**Year 2000:**

Region1	Region2	Region3	Region4	Region5	Region6	Others	Total
441	397	1050	500	2028	2023	95	6534

**Year 2001:**

Region1	Region2	Region3	Region4	Region5	Region6	Others	Total
490	416	1208	622	2081	2437	73	7327

**Year 2002:**

Region1	Region2	Region3	Region4	Region5	Region6	Others	Total
449	508	1361	725	2279	3215	61	8598

Step 2: resulted in **functional impairment** -

**Method a:** All adults with DSMIV # 295 – 298.9 **and** SSI/SSDI eligible

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Others	Total
Year 2000	203	237	469	309	1279	1387	62	3946
Year 2001	235	263	598	366	1381	1719	54	4616
Year 2002	228	294	634	434	1432	2252	39	5313

**Method b:** All adults with DSMIV # 295-298.9 **and** they are in community service

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Others	Total
Year 2000	350	280	683	318	1536	1508	80	4755
Year 2001	402	312	852	403	1465	1792	55	5281
Year 2002	401	412	1102	567	1772	2601	55	6910

**Method c:** All adults with DSMIV # 295-298.9 **and** they have an Axis V GAF score of less than 60.

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Others	Total
Year 2000	250	138	400	224	863	885	45	2805
Year 2001	295	172	516	272	932	1029	34	3250
Year 2002	233	202	587	282	909	1537	30	3780

### **Unduplicated Persons Served Meeting Federal SMI Criteria**

As a result of this method, the number of persons served who meet the Federal SMI criteria (unduplicated count) are found in an intersection of method a, method b and method c:

	FY2000	FY2001	FY2002
Clients in method a, b, and c (unduplicated count):	1298	1501	2106
Clients in method a only (not b & c)	405	303	100
Clients in method b only (not a & c)	759	721	960
Clients in method c only (not a & b)	176	458	155
Clients in method a & b only	2021	2290	2716
Clients in method b & c only	677	769	1128
Clients in method a & c only	438	522	391
Total SMI (unduplicated count):	5,774	6,564	7,556

Data source: Magellan Behavioral Health Data Base; analysis completed by the HHS Office of Mental Health, Substance Abuse and Addiction Services; August 7, 2002.

**STATE REGIONAL CENTER DATA (State Psychiatric Hospitals)**  
**Lincoln Regional Center, Norfolk Regional Center, Hastings Regional Center**  
**Adults, Age 18 or older, Inpatient (Actual)**  
Regional Center Data - Age 18+      FY2000 - FY2003

Number of <b>Admissions</b> to a State Regional Center				
<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	
1,096	1,086	1,097	1,115	Number of admissions
689	699	693	667	Number of admissions with SMI
533	453	430	551	Number of admissions with a substance abuse diagnosis

Number of <b>Discharges</b> from a State Regional Center				
<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	
703	714	614	660	Total discharges with SMI
1,178	1,094	1,087	1,165	Total discharges

Number of Patients-In-Residence in State Regional Center on the <b>Last Day of the Fiscal Year</b>				
<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	
291	285	322	295	Number of patients-in-residence with SMI
468	478	469	432	number of patients-in-residence on the last day of the FY

Average/median length of stay (in days) for persons with a SMI discharged from a State Regional Center				
<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	
215.7 days	153.7 days	185.9 days	159.0 days	Average length of stay
63.0 days	55.0 days	66.0 days	62.0 days	Median length of stay

Percent of Discharges from State Regional Center inpatient units who were Readmitted within 30 days of discharge				
<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	
4.2%	7.3%	7.5%	8.1%	Value
50	80	82	94*	Readmitted within 30 days
1,178	1,094	1,087	1,165	Number of discharges

Percent of Discharges from State Regional Center inpatient units who were Readmitted within 180 days of discharge				
<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	
14.6%	17.9%	15.4%	Not Av	Value
172	196	167	Not Av	Readmitted within 180 days
1,178	1,094	1,087	1,165	Number of discharges

\* estimated, based on 11 months of readmission data

Prepared by Paula Hartig, August 15, 2003; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

**Regional Center Unduplicated Persons Served  
Inpatient and Residential Services  
FY2000 - FY2003 Age 0-17**

	FY2000		FY2001		FY2002		FY2003	
	N	%	N	%	N	%	N	%
<b>TOTAL YOUTH SERVED</b>	70	---	106	---	118	---	112	---
<b>Age:</b>								
10-14 years	13	18.6%	13	12.3%	15	12.7%	24	21.4%
15-17 years	57	81.4%	93	87.7%	103	87.3%	88	78.6%
<b>Gender:</b>								
Male	58	82.9%	92	86.8%	93	78.8%	89	79.5%
Female	12	17.1%	14	13.2%	25	21.2%	23	20.5%
<b>Employment Status:</b>								
Student	68	97.1%	99	93.4%	109	92.4%	109	97.3%
Unemployed	2	2.9%	7	6.6%	8	6.8%	2	1.8%
Employed - Full-Time	0	0.0%	0	0.0%	1	0.8%	1	0.9%
<b>Race:</b>								
White	48	68.6%	80	75.5%	88	74.6%	87	77.7%
Black/African American	5	7.1%	9	8.5%	13	11.0%	11	9.8%
American Indian	7	10.0%	9	8.5%	6	5.1%	6	5.4%
Asian/Pacific Islander	2	2.9%	1	0.9%	1	0.8%	0	0.0%
Bi-Racial	4	5.7%	1	0.9%	4	3.4%	5	4.5%
Other	2	2.9%	2	1.9%	0	0.0%	2	1.8%
Not Reported	2	2.9%	4	3.8%	6	5.1%	1	0.9%
<b>Hispanic Origin:</b>								
Yes	6	8.6%	10	9.4%	12	10.2%	11	9.8%
No	64	91.4%	96	90.6%	106	89.8%	101	90.2%
<b>Legal Status at Admission:</b>								
Voluntary	19	27.1%	17	16.0%	11	9.3%	14	12.5%
Court Order	43	61.4%	64	60.4%	84	71.2%	71	63.4%
EPC	6	8.6%	23	21.7%	15	12.7%	22	19.6%
Other	2	2.9%	2	1.9%	8	6.8%	5	4.5%
<b>Diagnosis:</b>								
Conduct Disorder	19	27.1%	20	18.9%	2	1.7%	3	2.7%
Substance Abuse/Dep	16	22.9%	33	31.1%	53	44.9%	56	50.0%
Alcohol Abuse/Dependence	2	2.9%	10	9.4%	16	13.6%	6	5.4%
Major Depressive Disorder	3	4.3%	6	5.7%	2	1.7%	4	3.6%
Bipolar Disorder	8	11.4%	5	4.7%	7	5.9%	5	4.5%
Anxiety Disorder	6	8.6%	4	3.8%	0	0.0%	4	3.6%
Other	16	22.9%	28	26.4%	38	32.2%	34	30.4%

Prepared by Paula Hartig, August 15, 2003; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

**Regional Center Unduplicated Persons Served  
Inpatient Services FY2000 - FY2003 Age 18+**

	FY2000		FY2001		FY2002		FY2003	
	N	%	N	%	N	%	N	%
<b>TOTAL ADULTS SERVED</b>	1,270	---	1,260	---	1,375	---	1,353	---
<b>Age:</b>								
18-19 years	40	3.1%	69	5.5%	62	4.5%	65	4.8%
20-24 years	157	12.4%	126	10.0%	164	11.9%	172	12.7%
25-34 years	314	24.7%	322	25.6%	305	22.2%	342	25.3%
35-44 years	368	29.0%	355	28.2%	411	29.9%	371	27.4%
45-54 years	228	18.0%	226	17.9%	275	20.0%	267	19.7%
55-64 years	116	9.1%	111	8.8%	111	8.1%	96	7.1%
65-74 years	31	2.4%	30	2.4%	32	2.3%	27	2.0%
75+ years	16	1.3%	21	1.7%	15	1.1%	13	1.0%
<b>Gender:</b>								
Male	869	68.4%	939	68.7%	950	69.1%	897	66.3%
Female	401	31.6%	427	31.3%	425	30.9%	456	33.7%
<b>Employment Status:</b>								
Student	27	2.1%	49	3.9%	24	1.7%	39	2.9%
Unemployed	816	64.3%	855	67.9%	1,004	73.0%	996	73.6%
Disabled	202	15.9%	178	14.1%	182	13.2%	173	12.8%
Employed - Full-Time	154	12.1%	120	9.5%	110	8.0%	96	7.1%
Employed - Part-Time	36	2.8%	24	1.9%	24	1.7%	22	1.6%
Homemaker	3	0.2%	2	0.2%	4	0.3%	2	0.1%
Retired	27	2.1%	29	2.3%	22	1.6%	23	1.7%
Other	5	0.4%	3	0.2%	5	0.4%	2	0.1%
<b>Race:</b>								
White	1,096	86.3%	1,063	84.4%	1,174	85.4%	1,124	83.1%
Black/African American	114	9.0%	129	10.2%	141	10.3%	150	11.1%
American Indian	29	2.3%	34	2.7%	30	2.2%	34	2.5%
Asian/Pacific Islander	6	0.5%	7	0.6%	8	0.6%	11	0.8%
Bi-Racial	11	0.9%	10	0.8%	4	0.3%	13	1.0%
Other	13	1.0%	16	1.3%	11	0.8%	15	1.1%
Not Reported	1	0.1%	1	0.1%	7	0.5%	6	0.4%
<b>Hispanic Origin:</b>								
Yes	31	2.4%	26	2.1%	40	2.9%	49	3.6%
No	1,239	97.6%	1,234	97.9%	1,335	97.1%	1,304	96.4%
<b>Legal Status at Admission:</b>								
Voluntary	274	21.6%	213	16.9%	143	10.4%	122	9.0%
Court Order	116	9.1%	130	10.3%	138	10.0%	142	10.5%
Mental Health Board Commitment	806	63.5%	830	65.9%	1,045	76.0%	1,061	78.4%
EPC	30	2.4%	39	3.1%	43	3.1%	26	1.9%
Other	44	3.5%	48	3.8%	6	0.4%	2	0.1%
<b>Diagnosis (Axis I Primary):</b>								
Schizophrenia	310	24.4%	297	23.6%	437	31.8%	430	31.8%
Substance Abuse (alcohol/drugs)	192	15.1%	165	13.1%	185	13.5%	174	12.9%
Bipolar Disorder	142	11.2%	140	11.1%	165	12.0%	189	14.0%
Major Depressive Disorder	112	8.8%	105	8.3%	124	9.0%	106	7.8%
Other Psychoses	167	13.1%	175	13.9%	57	4.1%	55	4.1%
Sexual Disorder	88	6.9%	90	7.1%	126	9.2%	108	8.0%
Other	259	20.4%	288	22.9%	281	20.4%	291	21.5%

Prepared by Paula Hartig, August 15, 2003; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

**Demographic Overview of Mental Health Persons Served Nebraska Mental Health System  
Community Based Programs - Adults Served**

<b>Magellan Behavioral Health / Unduplicated Persons Served / Age 18+ FY2001, FY2002 and FY2003</b>						
	<b>FY2001</b>		<b>FY2002</b>		<b>FY2003</b>	
	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>		
<b>TOTAL ADULTS SERVED</b>	30,900	100%	33,821	100%	31,587	100%
<b>By Age:</b>	30,900	100%	33,821	100%	31,587	100%
18-20 years	3,045	9.9%	3,051	9.0%	2,238	7.1%
21-64 years	27,062	87.6%	29,966	88.6%	28,645	90.7%
65-74 years	493	1.6%	516	1.5%	430	1.4%
75 + years	300	1.0%	288	0.9%	274	0.9%
<b>By Gender:</b>	30,900	100.0%	33,821	100.0%	31,587	100.0%
Male	18,451	59.7%	19,982	59.1%	18,566	58.8%
Female	12,395	40.1%	13,796	40.8%	13,005	41.2%
Not reported	54	0.2%	43	0.1%	16	0.1%
<b>Employment Status:</b>	30,900	100.0%	33,821	100.0%	31,587	100.0%
Student	473	1.5%	367	1.1%	52	0.2%
Unemployed	6,171	20.0%	6,676	19.7%	6,784	21.5%
Disabled	1,359	4.4%	1,133	3.4%	663	2.1%
Employed - Full-Time	10,876	35.2%	10,818	32.0%	10,097	32.0%
Employed - Part-Time	3,865	12.5%	4,132	12.2%	4,169	13.2%
Homemaker	208	0.7%	151	0.5%	55	0.2%
Retired	135	0.4%	80	0.2%	45	0.1%
Other	6,985	22.6%	9,750	28.8%	9,434	29.9%
Unknown/Not reported	828	2.7%	714	2.1%	288	0.9%
						0.0%
<b>Race:</b>	30,900	100.0%	33,821	100.0%	31,587	100.0%
White	24,835	80.4%	27,378	81.0%	25,763	81.6%
Black/African American	2,587	8.4%	2,867	8.5%	2,459	7.8%
American Indian	1,025	3.3%	1,072	3.2%	1,048	3.3%
Asian/Pacific Islander	163	0.5%	167	0.5%	191	0.6%
Alaskan Native	27	0.1%	35	0.1%	35	0.1%
Other	1,943	6.3%	1,950	5.8%	1,719	5.4%
Unknown/Not reported	320	1.0%	352	1.0%	372	1.2%
<b>Hispanic Origin:</b>	30,900	100.0%	33,821	100.0%	31,587	100.0%
Yes	28,070	90.8%	30,838	91.2%	1,788	5.7%
No	1,954	6.3%	1,997	5.9%	28,874	91.4%
Unknown/Not Reported	876	2.8%	986	2.9%	925	2.9%
<b>Legal Status at Admission:</b>	30,900	100.0%	33,821	100.0%	31,587	100.0%
Voluntary	13,474	43.6%	15,065	44.5%	15,723	49.8%
Court Order	2,713	8.8%	2,782	8.2%	2,447	7.7%
Mental Health Board Commitment	1,001	3.2%	1,163	3.4%	1,640	5.2%
EPC	1,691	5.5%	2,552	7.6%	1,955	6.2%
Other	8,353	27.0%	8,782	26.0%	8,922	28.2%
Not reported	3,668	11.9%	3,477	10.3%	900	2.8%

**FY 2004 Nebraska MENTAL HEALTH PLAN  
PERFORMANCE INDICATORS**

**GOAL:** To maintain the number of people receiving Mental Health Services.

**OBJECTIVE:** To maintain the number of persons age 18 or older (unduplicated count) in FY2004 (no cut in program capacity).

**POPULATION:** Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS)

<b>Magellan Behavioral Health Unduplicated Persons Served / Age 18+</b>					
Performance Indicator	<b>FY2001 Actual</b>	<b>FY2002 Actual</b>	<b>FY2003 Actual</b>	<b>FY2004 Objective</b>	<b>% Attain</b>
M H Services only	14,816	15,962	17,328	17,000	

NOTE: the complete report includes the following information.

	<b>FY2001</b>		<b>FY2002</b>		<b>FY2003</b>	
<b>By Services:</b>	30,900	100.0%	33,821	100.0%	31,587	100.0%
MH only	14,816	48.0%	15,962	47.2%	17,328	54.9%
SA only	12,851	41.6%	13,832	40.9%	11,182	35.4%
Dual only	33	0.1%	34	0.1%	426	1.3%
MH/SA	1,156	3.7%	1,391	4.1%	1,723	5.5%
MH/Dual	15	0.1%	31	0.1%	15	0.0%
SA/Dual	7	0.0%	9	0.0%	1	0.0%
MH/SA/Dual	15	0.1%	19	0.1%	1	0.0%
Unknown	2,007	6.5%	2,543	7.5%	911	2.9%

This chart is the number of individual adults served by type of program.

- The **Mental Health Services (MH)** include Residential Rehabilitation, ACT, Community Support-MH, Day Treatment, Day Rehabilitation, Vocational Support, Day Support, Outpatient (Individual, Family, Group), and Medication Management.
- The **Substance Abuse Services (SA)** include Short Term Residential, Therapeutic Community, Halfway House, Community Support-SA, Outpatient (Individual, Family, Group), Detox, and Methadone Maintenance.

**Criterion 4: Targeted Services to Rural and Homeless Populations**

- Describes states' outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals residing in rural areas.

**Adult Criterion #4 - ADULT HOMELESS: The plan provides for the establishment and implementation of outreach to, and services for, such individuals who are homeless.**

As discussed under ADULT GOAL #2: CONTINUE TO IMPROVE QUALITY, DELIVERY OF SERVICES AND CONSUMER ACCESS, HHS Office of Mental Health, Substance Abuse and Addiction Services has a contract with HANNA:KEELAN ASSOCIATES, P.C. (Lincoln, NE) to focus on people who are extremely low income with serious mental illness needing housing.

- Project #1 statewide consumer housing need study (July 24, 2003) and
- Project #2- planning in four communities Omaha, Lincoln, the Norfolk Area & Tri-City Area (Hastings, Grand Island, and Kearney) (in process).

Under project #1, HANNA:KEELAN ASSOCIATES conducted a consumer survey (see State of Nebraska Mental Health Housing Study, page 2.7). This consumer survey used two methods of distribution: (1) a "point of contact" approach plus (2) 361 surveys mailed to National Alliance for the Mentally Ill – Nebraska chapter members. A total of 1,411+ surveys were distributed and 530 returned (37%). The consumer survey findings included the following:

- 34.2% were unable to work
- the average monthly income was \$650
- 39.8% of the consumers have been homeless at some point
- 9.6 % are currently homeless.
- 34.7% have been hospitalized in the last 12 months
- 6.8% lost their housing while they were hospitalized
- 19.8% do not have adequate transportation to needed services and employment
- 46.4% do not have a driver's license
- 41.5% report walking as their primary means of transportation

HHS Awards Emergency Shelter Funds \$2.5 million

In a press release issued on August 13, 2003, the Department of Health and Human Services (HHS) has announced grant awards of \$2,503,596 in Emergency Shelter Funds Statewide to community programs to address the needs of homeless people in Nebraska. These programs provide direct help to people in Nebraska who are homeless or close to being homeless. No area of the state is exempt from these concerns, and the money is spread across the state to make as big of an impact as possible.

The funds are from the federal Emergency Shelter Grant Program of the Department of Housing and Urban Development (HUD) and the state Homeless Shelter Assistance Trust Fund. Both are administered by Health and Human Services. Money in the state trust fund is based on a 25-cent set-aside on each \$1,000 of the value of real estate sold in Nebraska, and is collected through the documentary tax stamp on real estate sales.

The allocation formula this year used to distribute the funds uses a regional base amount, population, poverty, and HUD allocation factors. In addition, some "one time only" funds were available this year, including a redistribution of unused funds formerly allocated to support flood victims last year.

The grant's objectives are to provide immediate emergency and temporary shelter, address needs of homeless migrant farm workers, link housing assistance with programs to promote self-sufficiency, and prevent homelessness. Seventy-one projects were funded in the seven regions this year. Regional grant awards are Panhandle Region (\$187,721), North Central Region (\$298,858), Southwest Region (\$295,092), Southeast Region (\$461,543), Northeast Region (\$384,227), Lincoln (\$306,072), and Omaha (\$570,148).

Omaha and Lincoln receive additional Emergency Shelter funding directly from the Department of Housing and Urban Development. This year, Lincoln received \$75,000 and Omaha received \$207,100 from HUD. These amounts are taken into consideration when determining the statewide regional distribution formula.

### **Projects for Assistance In Transition from Homelessness (PATH)**

The Nebraska Department of Health and Human Services contracts with the Regional Governing Boards for delivery of community mental health services including contracts for the implementation of PATH Formula Grant activities.

#### Service Areas:

The two primary geographic areas within Nebraska that will be served by PATH funded programs are Lincoln (Region V) and Omaha (Region VI). Services will also be provided in two locations in the rural western part of the state: Scottsbluff (Region I) and Grand Island (Region III).

#### Organizations to Receive Funds and Amounts Allocated:

Region 1 – Western Nebraska Scottsbluff	Cirrus House: (Private non-profit entity)	\$11,333	4%
Region 3 – Central Nebraska Grand Island	Central Nebraska Goodwill Industries, Inc. (Private non-profit)	\$11,333	4%
Region 5 – Southeast Nebraska Lincoln and Lancaster County	Community Mental Health Center/Lancaster County (Public, County Governmental Entity)	\$32,500	11%
	CenterPointe, Inc. (Private, non-profit)	\$32,500	11%
Region 6 – Eastern Nebraska Omaha and Douglas County	Community Alliance (Private, non-profit)	\$147,700	51%
	Salvation Army (Private, non-profit)	\$53,300	18%
TOTAL		\$288,666	100%

#### Services to be supported by PATH Funds:

The PATH programs will provide outreach, screening and diagnostic treatment services, case management, referral, some temporary housing assistance, and other appropriate services to individuals who are suffering from serious mental illness or are suffering from serious mental illness and from substance abuse, and are homeless or at imminent risk of becoming homeless.

#### Number of Persons to be served:

The estimated number of persons that will be served in FY03 statewide is 524.

#### Funding Mechanism:

The funding mechanism used by Nebraska to distribute PATH funds is by region. The process used to allocate PATH funds is based on a combination of factors: 1) continuation of funding to maintain services established under previous three years PATH and Mental Health Services for the Homeless (MHS) grants, 2) the number of individuals served with those funds, and 3) the current state financial limitations, which have resulted in the resending of a previous practice of allocating all the

funds to providers. Based on the evidence of need presented, and the fact that Lincoln and Omaha have the greatest numbers of homeless individuals in Nebraska, the PATH funds will continue to be directed primarily to those areas of the state.

#### **Criterion 4: Targeted Services to Rural and Homeless Populations**

- **Describes states' outreach to and services for individuals who are homeless;**
- **Describes how community-based services will be provided to individuals residing in rural areas.**

#### **Criterion 4 Rural Populations: Describes how community-based services will be provided to individuals residing in rural areas.**

Under Criterion 2, using 2000 Census data, 899,838 (52.6%) of the 1,711,263 residents in Nebraska live in six (6) counties classified as Metropolitan Areas. That means there are 811,425 (47.4%) residents who live in Micropolitan (10,000 to 49,999 residents), Rural or Frontier (less than 7 persons/sq.mi.) areas.

Most of this Federal Mental Health Block Grant application has been addressing how community-based services are provided. From the Nebraska Office of Mental Health, Substance Abuse and Addiction Services point of view, the same general approach is used within each geographic area. Regional Governing Boards exercise "local control" in partnership with the State of Nebraska. This local control is very important due to the challenges of providing services in each of these four types of geographic areas (Metropolitan, Micropolitan, Rural or Frontier). There must be flexibility in delivery/provision of "accessible" mental health services in each of these four types of areas.

In addition to these services offered via the Regional Governing Boards, there is one specialized rural program Nebraska funds. It is the Rural Mental Health Hotline and Voucher Program.

#### **Rural Mental Health Hotline and Voucher Program**

This program provides hotline and crisis counseling services to the rural residents of Nebraska. The demand for these services continues to increase as those who derive their livelihood from the rural economy continue to face the stress of low prices, increased costs, and drought.

Rural residents calling the toll-free Nebraska Farm Hotline who present to be in need of professional mental health treatment are informed of the "Voucher Program". The "Voucher Program" is designed to make cost-free, confidential mental health counseling available to persons affected by the current rural crisis. The program is not limited to farmers. Any rural person who is negatively impacted by the rural crisis may apply. This includes farm family members, those employed in agriculture-related businesses and small town businesses dependent on the agricultural economy, and other rural residents.

Upon request from the caller, Farm Hotline staff mails a voucher with a list of mental health providers in their geographic area and contact information. Each voucher pays for one outpatient session. The caller has 30 days to redeem the voucher by receiving counseling from an approved provider. If more than one session is needed, up to 5 additional vouchers for therapist prescribed sessions can be obtained by calling the Hotline. Additional sessions are provided free by the provider as the need in the rural/frontier areas is critical. Mental health providers are reimbursed at the rate of \$50.00 for each 50-60 minute session provided.

Currently, 197 licensed (a requirement) mental health providers in every part of the state have signed on to provide services under the Voucher Program. As of June 2003, 57 providers were currently active. A large number of providers have strong farm backgrounds and an understanding of rural culture.

The voucher program is managed on a per month allotment so the program will have funds for the entire year. For FY 2004, the funding to the “Rural Mental Health Crisis Counseling Program” is \$100,000.

**GOAL:** With the Rural Mental Health Program, provide services to the rural residents of Nebraska impacted by the prolonged decline of the farm/rural economy in Nebraska.

**OBJECTIVE:** In FY2004, provide 2,500 counseling sessions to 800 people (individuals or families) under the crisis counseling vouchers program.

**POPULATION:** Residents of Nebraska's rural and frontier areas including farmers, ranchers, spouses, children, and others who are directly affected by the continued economic crisis.

Value: average number of sessions per individual/family

Numerator: unduplicated count / people served (individual or family)

Denominator: total number of counseling sessions

Performance Indicator: (1)	FY2001 Actual (3)	FY 2002 Actual (4)	FY2003 Actual (5)	FY2004 Objective
Value:	5.73	4.2	2.4	2.5
Numerator	229	625	845	800
Denominator	1312	2625	2025	2000
Discussion: – In FY2000 and FY2001, the Rural Mental Health Hotline and Voucher Program budget was \$50,000 (Hotline \$20,000; Voucher program \$30,000). – In FY 2002, the Rural Mental Health Hotline and Voucher Program budget was increased to \$100,000. (Hotline; \$20,000; Voucher program \$80,000). In FY 2003 and FY 2004, the budget remained at the same level of funding as FY 2002. In FY 2004, the \$100,000 was moved to the Voucher Program.				

Data source: from NE Office of Mental Health, Substance Abuse and Addiction Services

**Criterion 5: Management Systems**

- Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan
- Provides for training of providers of emergency health services regarding mental health
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved

**Financial Resources****How The State Intends To Expend The Grant Under Section 1911**

See SECTION III – STATE PLAN, “A. Fiscal Planning Assumptions” for details on how the state intends to expend the grant under Section 1911.

**Training Of Providers of Emergency Health Services. NOTE: this material applies to both Adults and Youth.**Mental Health Board Training

Mental Health Board Training is authorized in Neb. Rev. Stat. § 83-1018 (4) "The Department of Health and Human Services shall provide appropriate training to the members and alternate members of the board on a yearly basis." There are twenty-eight (approximately) boards of mental health across the state.

Participants invited to the training each year include Regional Center Emergency Coordinators, Crisis Center Directors, Regional Program Administrators, members of the Boards of Mental Health, County Attorney's, Public Defender's, Clerks of the District Courts, State Alcohol and Drug Abuse Advisory Council, Mental Health Planning and Evaluation Council, Regional Center personnel as well as HHS staff.

The 2002 training used new approach involving a self-study approach. Here, the individual reviewed several case studies and then complete a series of questions. A second approach being developed will involve an “in-person” method. Here, Nebraska mental health commitment board members would present some of their successful approaches in addressing the demands made in the civil commitment process. Approximately 50 completed the self-study.

The 2002 training was provided by Lee Tyson, Region I Mental Health and Substance Abuse Coordinator of Emergency Psychiatric Services, Sonya Charlton, Region West Medical Center Emergency Services Coordinator, Ron Kelly, Box Butte County Board of Mental Health, Dr. Fred Koch, Box Butte Board of Mental Health, Marsha Meyer, Jud. Dist 12, Central Board of Mental Health and Christine Sheldon, Region West Medical Center. The training consisted of discussions of case scenarios by three Board Members. The trainings were held in North Platte and Mahoney Park. 12 Board Members attended the North Platte training and fifty Board Members attended the Mahoney Park training.

Emergency Management

The Department continues to work with the Nebraska Emergency Management Agency regarding various issues related to the development and, when / if needed, implement the State mental health response plan. Officially, the STATE EMERGENCY OPERATIONS PLAN

ESF # 8 HEALTH AND MEDICAL SERVICES, III. MENTAL HEALTH RESPONSE & RECOVERY is posted on the NEMA web site at <<http://www.nebema.org/esf8.html>>.

Under a section titled "E. Organizational Roles and Responsibilities" there is a discussion on the roles of responsibilities of each of the key organizations involved in a mental health response, if one is required:

1. HHS-Office of Mental Health, Substance Abuse, and Addictions Services
2. HHSS- Department of Regulation and Licensure - Nebraska Critical Incident Stress Management Program (CISM) as provided by Neb. Rev. Statute. §§ 71-101 to 71-7113.
3. Nebraska Emergency Management Agency (NEMA)
4. American Red Cross (ARC)

Regarding local mental health disaster response planning, recently Office of Mental Health, Substance Abuse and Addiction Services staff started working with "Omaha Metro Medical Response System Steering Committee". This is a major planning effort for the Omaha Metro Area. The Committees include Communications, Equipment/ Training, Hospital, Lab/ Infection Control/ Surveillance, Media, Mental Health, Pharmacy, and Surveillance. Specifically, Office staff is working with the Mental Health Committee.

Mental Health Disaster / Emergency / Crisis Response Training continues. Teaching disaster mental health response to local emergency managers covering why disaster mental health response is necessary, FEMA Crisis Counseling, the American Red Cross mental health response role, critical incident stress management (CISM), and writing a local mental health response plan has been completed twice in the last few years. A pilot class on disaster mental health response and taught it July 1999 in Kearney, NE. The material was updated and taught as "Disaster Mental Health Response & Recovery" on May 2, 2001 in Lincoln and as "Understanding Posttraumatic Stress Disorder" on June 1, 2001 at the Nebraska Statewide Critical Incident Stress Management Thirteenth Annual Conference in Grand Island.

Now there is a planning process with the Omaha Metro Medical Response System Mental Health Committee. Office staff attend the monthly meetings of this group.

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A grant application was submitted to the Nebraska Health Care Cash Fund for 2002 on April 2, 2002 titled, "Developing a Statewide Behavioral Health Response to Terrorism and Other Disasters". In September 2002, the Nebraska Department of Health and Human Service received a \$33,319 grant from the Nebraska Health Care Cash Fund.

These grant funds were used to sponsor the "NEBRASKA DISASTER MENTAL HEALTH CONFERENCE." This conference was held on July 10-11, 2003 at the Omaha Doubletree Hotel Downtown. The Target Audience was psychiatrists, psychologists, social workers, mental health care providers, public health officials, nurses, clergy, substance abuse workers, and emergency managers. Officially, 294 attended.

To open the conference on July 10, 2003, there was an address by Governor Johanns. Other presenters included:

- Robert DeMartino, M.D., Associate Director for the Program in Trauma and Terrorism, SAMHSA
- Anthony T. Ng, M.D., Medical Director, Disaster Psychiatry Outreach

- Gilbert Reyes, Ph.D., Assistant Professor, Disaster Mental Health Institute, University of South Dakota
- Rev. Christine Iverson with the Lutheran Disaster Response
- Phebe Tucker, M.D., Professor and Vice Chair of Education with the Department of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center
- Rabbi Alan G. Weitzman and Reverend Foster R. McCurley, Ph.D.

The Conference Objectives were:

- Educate behavioral health professionals in traditional and faith based organizations about mental health interventions and treatment to reduce the emotional impact of terrorism and other disasters.
  - Inform local emergency managers and public health officials about the role of a mental health response in terrorism and other disasters.
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### Critical Incident Stress Management

Critical Incident Stress Management (CISM) Program is a key resource for Nebraska's capacity to provide mental health disaster response services. The CISM program is authorized by the "Critical Incident Stress Management Act (Neb. Rev. Stat. §§ 71-7101 to 71-7113)". There are five State of Nebraska Departments sponsoring this program:

- Department of Health and Human Services Regulation and Licensure / Emergency Medical Services (EMS) Program
- Department of Health and Human Services / Office of Mental Health, Substance Abuse and Addiction Services
- Nebraska State Patrol
- State Fire Marshal
- Nebraska Emergency Management Agency

Please note that Office of Mental Health, Substance Abuse and Addiction Services staff serve on the CISM Interagency Management Committee.

The Nebraska Critical Incident Stress Management Program trains volunteers to provide crisis support to reduce the harmful effects of critical incident stress for; law enforcement officers; firefighters; emergency medical services, corrections, hospitals, and emergency management personnel; and dispatchers. There is an annual conference (first weekend after Memorial Day) where a lot of training on mental health disaster related topics occurs.

The core functions of the Nebraska Statewide Critical Incident Stress Management Program are:

- Recruitment and retention of volunteers (training, continuing education);
- Intervention services (defusings, debriefings, referral);
- Prevention (education, consult agencies).

For more information on this program see <<http://www.hhs.state.ne.us/ems/emscism.htm>>.

### **Other Training For Mental Health Service Providers**

NAMI- NE is to develop an infrastructure for a mental health education, support and advocacy presence in Nebraska and to provide specific family education , support, information, advocacy and related functions for consumers of mental health services and their families in Nebraska. One of the consumer liaisons serves as a trainer in NAMI-NE's "Journey of Hope" training's.

Magellan Provider Training – Magellan Behavioral Health continues to provide training with all contract providers on managed care issues with the renewal of the ASO contractor effective January 1, 2000.

The Department will continue to sponsor trainings for consumers/providers covering the recovery concept. For example, the Department continues to support the Aurora, Nebraska conference designed to provide training to consumers. There are 130 consumers expected to participate in each year's conference. Most of these consumers are users of the Department funded psychiatric rehabilitation programs. The Consumer Conference is usually held in September.

Suicide Prevention Curricula being delivered via a train the trainers model. This model develops and maintains local expertise in suicide prevention. The target population for this pilot was adults in Southeast Nebraska with emphasis on reaching those at highest risk for suicide. For more information, see ADULT GOAL #4: SUICIDE PREVENTION INITIATIVE.

<b>FY 2004 Nebraska MENTAL HEALTH PLAN PERFORMANCE INDICATORS</b>
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<b>Population: SMI Adults</b>
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<b>Criterion 5: Management Systems</b>
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**GOAL:** At least maintain the Per Capita State Expenditures for Community Mental Health Services

**OBJECTIVE:** By June 30, 2004, the per capita state expenditures for community mental health services will be maintained over \$15.00

**POPULATION:** Total population

**Per Capita State Expenditures for Community Mental Health Services**

Numerator = FY2001 and FY2002 is “actual” Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Numerator Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = Total State population

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001 <<http://info.neded.org/stathand/bsect8.htm>>

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY2004 Objective	% ATTAIN
Value:	\$14.03	\$16.97	\$17.46	
Numerator	\$24,015,746	\$29,036,852	\$29,874,816	
Denominator	1,711,263	1,711,263	1,711,263	

# **Nebraska FY2004 Community Mental Health Services Block Grant Application**

## **SECTION III – STATE PLAN**

### **CHILDREN’S PLAN**

#### **Section II – Children State Plan Context**

##### **Children Goals**

- A. State public mental health service system as it is envisioned for the future
- B. Previous State plan
- C. New developments and issues

#### **SECTION II – STATE PLAN CONTEXT – Children and Families Section**

##### **A brief description of the state public mental health service system (for children and adolescents) as it is envisioned for the future**

Based on data which indicates areas of need, the state has the ability to plan for a public mental health system in which all children with mental health needs have access to a comprehensive, integrated system of care that meets the following principles:

- Community based, with the locus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Provide access to a comprehensive array of effective services that address the child’s physical, emotional, social, and educational needs.
- Individualized services in accordance with the unique needs and potentials of each child and guided by an individualized support plan.
- Provision of early identification and intervention in order to enhance the likelihood of positive outcomes.
- An array of services which support youth

##### **The desired outcome for the children’s public mental health system:**

- Movement from a fragmented system to an integrated system.
- Funding agencies, in conjunction with families, providers and communities, coordinate policy development, needs assessments, planning, service development, funding, program evaluation, utilization management, information management, and quality improvement.
- Families are organized to support and advocate for one another and are included at every level of decision making.
- Service providers are joined in a network to coordinate care and to ensure services are high quality. Communities organize resources and supports to help children and families.
- All youth with Serious Emotional Disturbances will receive services which enhance their ability transition successfully into adulthood with minimal disruption in service and maximum success potential.

## **Children's Goal #1: Strategic Planning**

### **A. The state service system as it is envisioned for the future:**

To implement a data based strategic planning process, which supports a comprehensive service system for all children with serious emotional disturbances and their families, through early childhood to their transition to adulthood.

### **B. Previous State Plan**

From the previous plan, Goals #2 and #4 were subsumed under the new Goal #1. These goals included:

**Goal #2:** To expand mental health services to youth in the juvenile justice system, and

**Goal #4:** Expand wraparound to rural population

The rationale for collapsing these goals is described in the "Gaps Section" regarding children's services. Services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. However, we believe it is prudent to revisit these gaps on a periodic basis to determine if services have been increased to these populations, and to make adjustment in the expansion of targeted populations based on current needs as supported by data.

### **C. New Development and Issues**

There were changes in the children's service systems during the past year: new projects funded, funding eliminated and subsequently projects "defunded". All of the new information has added to the overall confusion of who is being served, and what areas need to be prioritized for development and funding in order to reach more children needing services.

As previously stated, in Nebraska's FY03 Medicaid funding was reduced. A major part of the bill that passed eliminates Medicaid coverage for 19- and 20-year-olds who live alone and make less than \$392 a month, known as "Ribicoff" coverage. The state estimates that more than 3,100 low-income young adults statewide will lose Medicaid eligibility. It is believed that these health-care costs are going to be shifted to other systems. Also eliminated is a presumptive eligibility provision for low-income children. It is estimated that about 20 percent of children who receive services under presumptive eligibility are later determined not to be eligible for Medicaid. By eliminating the presumptive eligibility provisions, about 340 children a month will receive services. This will significantly impact children's eligibility for behavioral health service, and has potential for cost shifting to the already overburdened public behavioral health system. **Source:** Lincoln Journal Star, July 18, 2003

Additionally, children may not be able to access mental health services until their parents have relinquished custody or they have become involved with the criminal justice system.

In FY03, the Office of Protection and Safety issued a request for proposals for provision of Multisystemic Therapy, which was to be funded by Medicaid. The target population to receive MST services included youth ages 10-20, diagnosed with a DSM-IV mental health disorder, placed out-of-home or at risk of an out-of-home placement, involved in the juvenile justice system or at-risk of

committing a criminal offense, and experiencing school failure, or at-risk of dropping out or being expelled from school due to behavior problems. This proposal was eliminated as funding was not available for new services without pulling funds away from current services.

New programs for target children continue to be developed using funds from outside the mental health system. One such funding initiative is the Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) Federal Grant. VOI/TIS funding is offered by the federal government to assist states in addressing issues of violent offenders and overcrowding in their juvenile correctional facilities. Nebraska was awarded VOIT/TIS funding in the amount of approximately \$4 million to increase bed capacity for violent juvenile offenders and to address issues of overcrowding in the Youth Rehabilitation and Treatment Center (YRTC) in Kearney. Nebraska is required to provide a 10% match. Nebraska identified two specific services to assist the YRTC in Kearney to address their overcrowding. HHS/OJS and the facility are working to implement and operationalize these two programs at the present time. One program being established is a sexual offender program, and the other is a culturally sensitive transitional program for African-American youth. All youth referred to either of these programs will remain committed to the YRTC-K, but be served at a site other than the main campus. The alternative site programs will be self-contained and offer specialized services to meet the behavioral, emotional, and physical needs of these particular youth.

The Sexual Offender Program will be located in Lincoln and will be able to serve approximately 7-9 male juveniles. Youth in this program will have significant functional impairments due to emotional disorders, as well as cognitive and/or sexual behavioral impairments. They will have persistent patterns of disruptive behavior and disturbance in age-appropriate adaptive functioning, and be at very high risk for causing harm to self or others. Youth will receive specialized services to address their sexual offender issues and other issues impacting their daily functioning.

The Transitional Living Program will be located in Omaha and will be able to provide culturally sensitive alternative programming for 8-10 African-American juvenile males instead of traditional programming at YRTC-Kearney. This program will concentrate on teaching these youth viable independent living skills for success in the future and to divert them from any future delinquent behaviors. Youth in this program will also have significant functional impairments due to emotional disorders and possibly have cognitive impairments. They will have persistent patterns of disruptive behaviors, disturbance in age-appropriate adaptive functioning, and be at risk for causing harm to self or others. In addition, they will receive services to improve upon their lack of vocational, interpersonal, and social skills generally considered necessary to live in the mainstream of society and be drug-free, free of criminal behavior, and legitimately successful. Offering such a culturally sensitive program will also enable the department to begin to address the issue of disproportionate minority confinement (DMC). These programs offer exciting opportunities for youth targeted to be served.

Nebraska Health and Human Services, with assistance from NASMHPD, sought technical assistance from the Bazelon Center for Mental Health Law in resolving the issue of custody relinquishment of children in order for them to access mental health services. Nebraska Federation for Families and the integrated finance committee from the two federal grant sites participated in conversation and presentations with Mary Giliberti, JD, from the Bazelon Center that explored alternative access to services for families who historically may have surrendered custody of their children to the state in order to receive Mental Health services. The proposal to explore funding for wraparound services funded by the Children's Medicaid Waiver was initiated, but again fell by the wayside in response to proposed Medicaid cuts.

Three new wraparound programs (Integrated Care Coordination Units-see Goal 3) for state wards have been funded by the Office of Protection and Safety, and provide new opportunities for youth in the Protection and Safety system (see criteria #3). It is anticipated that cost savings from the ICCUs may be appropriated to prevent custody relinquishment (funding wraparound services for non-wards).

In relationship to strategic planning, it should be noted that the position of Health and Human Services Children's Mental Health Administrator was vacated at the beginning of FY03. This position has "intra-agency" responsibilities for planning and developing mental health services for children. This position has not been filled at this time.

In summary, we know that an increased number of children in Nebraska are receiving services. Each of these new projects was developed to provide mental health and other supports for children and their families within targeted populations (state wards, juvenile justice children). We need data to be able to evaluate what gap exists in services today. We will gather data from existing systems (public system, child welfare, Medicaid, juvenile justice system, etc.) to determine who is being served currently, and who is not being served. We can then develop a strategic plan to meet unmet needs.

## **State Children's Goal 2: Family Support**

### **A. State Service System as it is envisioned for the Future:**

The goal is to support comprehensive, community-based family peer mentoring for families of children with emotional, behavioral, and mental health issues.

- Support is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- Services are within the least restrictive, most normative environment that is clinically appropriate.
- Families and surrogate families should be full participants in all aspects of planning and delivery of services.
- Family organizations receive support from multiple initiatives, increasing financial viability

### **A. Previous State Plan**

**FY03 Goal #1** To provide comprehensive, community-based family support for families of children with emotional, behavioral, and mental health issues.

### **C. New Developments and Issues**

New Projects involving the support of families include:

The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services offered a proposal to solicit bids for a new support activity called "**Families Mentoring & Supporting Other Families**", a joint initiative to request proposals from qualified sources to provide:

- A. Strength-based, family centered, and partnership oriented supports to:
  - 1) parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or

- 2) parent who are involved with the department as a result of a report of abuse/neglect, or
  - 3) parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders.
- B. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The Department sought an organization interested in working with the State to build support services to families that will focus on providing parents with an understanding of wraparound services through peer role modeling and coaching. The philosophy of wraparound includes individualized services that are developed through professionals and parents in partnership where both are serving important roles in service delivery. Services are tailored to meet the individualized needs of the child and family and based upon strength-based assessments.

The outcomes for parents served will be:

1. To have support of other families that are coping with similar challenges.
2. To reduce parental feelings of emotional and social isolation that sometimes occur in parenting a child with emotional and behavioral challenges.
3. To have referral sources to access the appropriate services for their child and other family members.
4. To be equal partners in the system of care.
5. To learn how to enhance communication and networking with the professionals involved in the case.

The program objectives are to form one parent organization within each of the service areas/regions, for all individual parent organizations awarded contracts to come together and form a consortium so there is some commonality and consistency between the service areas/regions organizations and an opportunity for statewide issues to be addressed. HHS will have a collaborative relationship with the consortium. The consortium members may be required to meet with HHS via telephone conference calls on a quarterly basis and in-person one-two times per year. They will deliver parent to parent supports that are efficient, effective and responsive as well as tailored to the unique and individualized needs of the child and family and measure and demonstrate the parent outcomes outlined above.

Supports purchased for parents will include:

- ◆ one on one mentoring and coaching of parents by other parents that have/are experiencing similar issues;
- ◆ contact with the family (frequency and type to be determined by the family) if the family chooses to have such home visits and/or phone calls;
- ◆ general advocacy and support (i.e. at child/family team meetings)
- ◆ training and empowerment resulting in effective working relationships with case managers, teachers and other professionals;
- ◆ help identify family strengths to nurture positive team interactions
- ◆ education regarding parental rights and responsibilities as it relates to Nebraska HHS systems of care;
- ◆ assistance in interpreting the case plan, court documents, the Individual Educational Plan (IEP) process, medical documents and service/treatment plans; and

- ◆ professional referral resources as appropriate per individual child/family needs. (i.e. navigating to other available resources and opportunities)
- ◆ coordinate volunteers to assist with parent supports

All supports are required to be community-based and provided at the local community level. Organizations must ensure supports have the capacity to address the unique culture of each family and child. Organizational supports need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. Organizations must integrate diversity into their practices and products so that interactions with individual children and their families can be mindful of, and honor, the family's home culture.

One organization has been selected from each of service areas of Health and Human Services and the corresponding mental health and substance abuse regions to develop a program that will provide supports to targeted families (1) whose children have been made state wards, (2) are involved with the department as a result of a report of abuse/neglect, or (3) whose children are diagnosed with a severe emotional disturbance and substance dependence disorders.

Family organizations selected for this proposal are also targeted to contract with the Integrated Care Coordination Units funded by the Office of Protection and Safety to perform various responsibilities in support of families for the ICCUs. Receiving funding for different initiatives increases the financial viability of the parent organizations, although concentrating funding to specific organizations may limit options for parents.

Additionally, the Munroe Meyer Institute – University of Nebraska Medical Center and Parent Training and Information of Nebraska have developed and piloted a \$266,000 project which involves a family led mentoring system for families of all cultures of children with disabilities who need flexible, family centered support services. The **“Families Unite” Project** matches trained mentors with newly identified parents and families. It is the goal of the project to assist families in accessing services and advocating for their family member with a disability. The philosophy, like other mentor projects nationwide, is based on the belief that one of the most meaningful sources of support for a family with a child with a disability are other parents who have experienced parenting a child with a disability. The project is based on a needs assessment survey, initiated in the fall of 2001, the Unite Council review and small work group recommendations. There are guidelines and responsibilities to help make this experience meaningful and productive.

A Project Coordinator will be responsible for assigning all matches. Before making any match, the project coordinator will consider the interests, skills, background, time availability, personal preferences and knowledge of both the parent mentor and the family seeking a mentor. The Family Mentor Pilot Project will provide all training to the mentors. The mentors are required to attend all training and networking sessions. All mentor candidates will be supplied with a detailed application form, self assessment form, and a reference form. The information from these forms will be sent to the funding source. Once all information has been received the application will be forwarded for approval to become a mentor. Once the mentor application has been approved the Project Coordinator will begin the matching process which is designed to meet the individual and specific needs of families.

The Project Coordinator will match a family regarding their specific needs. It is imperative that the mentor keep the Project Coordinator informed of the monthly activities regarding assisting the family meeting their specific needs. All information shared by the Project Coordinator about the family is strictly confidential; a mentor sharing information with others may inadvertently violate the

law. The mentor should be clear with the parent(s) or family that the mentor **cannot** legally keep information regarding sexual, emotional, or physical abuse confidential. The mentor should immediately report such information to a project coordinator, making a note as to when the information was reported and to whom.

The project will be providing a monthly stipend to the mentor for services provided. Therefore, the mentor will refrain from giving and receiving payments of any kind (i.e. gifts of money, food, extravagant outings, presents or fees). The project will provide mentors with training regarding personal and family rights and responsibilities. The mentor therefore must respect the rights and wishes of the parent/family. One must be careful of making judgmental assumptions. Mentors will be paid a stipend by the project to participate in training and networking sessions. All training sessions are mandatory. When mentors are matched with families they will be paid a stipend for the month(s) they are mentoring a family. Matching is done on an individual basis. Everyone may not be able to be matched, you may in the end not be matched and stipends will discontinue at that time. If the funding of the grant ends, the funds will end for stipends for training and mentoring a family.

Mentors will be available to families as reasonably needed. Mentors will complete 3 training modules before they may be matched with a parent/family. After matching, mentors will continue to meet with the Project Coordinator once a month for on-going support and training. This time offers mentors and the Project Coordinator the opportunity to discuss and monitor on-going progress, problems and victories of the mentoring relationship. Mentors are also expected and encouraged to participate in special family mentor projects events from time to time.

Overall objectives of the Families Unite proposal include continuance of Unite's Family Policy Council to guide the project, implementation of the family mentor system and evaluation of the feasibility of the pilot to demonstrate the benefits of the family mentor system to both families and state service systems. Source: Proposal for UNITE, Family Mentor Pilot Project, May, 2002.

Although the number family support projects continue to increase, a large number of caregivers of children with disabilities, including SED, continue to live in isolation without support. A large number of grandparents are now raising their grandchildren, and a proportionate number of those children have disabilities. For example, at the Youth Provider Meeting, Region I Behavioral Health, February, 2003 this problem was discussed. Providers reported that they are observing a trend in the number of grandparents who are raising their grandchildren. The grandparents have reported that programs which recognize the unique needs of older adults raising children with disabilities seem to be virtually nonexistent in Nebraska.

Additionally, family members have argued that the number of family organizations funded by the state is inadequate, stating that "one size does not fit all". In the next fiscal year, we will be evaluating the efficacy of organizations currently receiving funding, as well as how organizations can be supported in ways other than funding.

### **State Children's Goal #3: Integration of Service Systems**

#### **A. State Service System as it is envisioned for the Future:**

We will collaborate across child serving systems to provide a system of integrated services for children with serious emotional disorders who have multiple and complex needs.

- Services are integrated, with linkages among child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.

- Case management ensures that multiple services are delivered in a coordinated and therapeutic manner and services and supports are adapted to the child's changing needs.

## **B. Previous State Plan**

FY03 Goal #3: To provide a system of integrated services for children with serious emotional disorders who have multiple and complex needs

## **C. New Developments and Issues**

The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services under Health and Human Services have been meeting monthly for approximately the past year to collaborate on youth and family issues. The meetings provide a means for the offices to share information and collaborate on projects.

The Office of Protection and Safety, Medicaid/Managed Care, and Office of Mental Health, Substance Abuse and Addiction Services are collaboratively working to make improvements to the Office of Juvenile Services (OJS) pre-disposition residential and non-residential evaluations for delinquent youth. The offices are redesigning the OJS evaluation and components of the mental health and substance abuse models used for assessments and evaluations so that information collected on a youth can more effectively assist the court and agencies in making appropriate care, placement and treatment decisions for youth. The newly designed evaluations will be used starting in approximately October 2003.

For younger children, Nebraska Health and Human Services has submitted an application to the U.S. Maternal and Child Health Bureau for the **State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program**. Nebraska state agencies, in partnership with professional organizations, community-based providers, families, and advocates, have made significant progress in addressing various aspects of early childhood systems of care. Several initiatives have resulted in planning documents and pilot projects. A major challenge that remains is to achieve an integrated, comprehensive plan that addresses the five key components of: (1) access to health care and a medical home; (2) **mental health and socio-emotional development**; (3) early care and education/child care; (4) parent education; and (5) family support. In addition, a number of other challenges are being faced in Nebraska that impact upon the health and well-being of Nebraska's young children and their families and the system that supports early childhood programs and services. Among these are an increasingly diverse populations and large expanses of rural and sparsely populated areas. In addition, gaps exist in data availability and utilization, including an absence of agreed-upon early childhood indicators.

The goal for this proposed project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a strategic plan and the ultimate realization of improved outcomes for young children and their families. Objectives include:

1. Establish a planning structure and process that engages the full spectrum of early childhood stakeholders, with an emphasis on family involvement;
2. Develop vision and mission statements and identify key outcomes for young children and the early childhood system in each of the five essential components;
3. Develop a set of indicators linked to outcomes;
4. Identify and rank priority needs and issues in each of the five essential components;
5. Develop strategies and associated action plans for each of the priority needs and issues;

6. Obtain commitments to accept and implement the strategic plan from key policy makers; and
7. Develop a comprehensive plan for sustaining the effort.

A participatory planning process, using a comprehensive planning model, has been selected as the methodology. This model meets the criteria of bringing together various and diverse organizations and individuals to create consensus and make prudent decisions about the future of early childhood comprehensive systems. This model is based on six basic steps: (1) issue identification/orientation, (2) exploration/investigation, (4) defining the planning of task or goal setting, (4) policy formation, (5) programming, and (6) evaluation. A consultant will guide participants in the process, and provide technical assistance to build stakeholder capacity to carry out the plan and continue planning efforts in the future. A full-time project coordinator will work with an Advisory Committee, a Project Leadership Team, and eight Work Groups.

The Governor-appointed Early Childhood Interagency Coordinating Council (ECICC) will serve as the Project Advisory Committee. The ECICC has done extensive work in examining early childhood care and education issues, and its membership represents a wide range of interests, including child care providers, state agencies, parents, business, health care providers, and others. In addition, a 20 – 30 member Project Leadership Team will engage representatives of state agencies, Tribal government, provider and family associations, advocacy groups, the business community, military installations, and other important stakeholders. Eight work groups will further facilitate involvement and coordination with state-level and community-based efforts. Planning activities will actively build on earlier and existing initiatives.

The project will measure progress in achieving seven planning phase outcomes and five short-term implementation outcomes. The planning phase outcomes are: (1) linkages formed among system and community/client stakeholders; (2) planning structure and staff established and functional; (3) workgroups formed, oriented to process, and prepared to carry out assignments; (4) community/stakeholder vision and mission developed; (5) strategies consistent with vision and mission; (6) policy changes identified to drive implementation phase; and (7) public support for change enhanced. The five short-term implementation outcomes are: (1) a model for shared decision making disseminated system wide; (2) improved capacity among stakeholders in the area of policy development; (3) information and administration infrastructure in place to increase exchanges; (4) system improvement resulting from training and coaching of stakeholders; and (5) ongoing stakeholder participation and data to improve early childhood systems planning.

The goal of this project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a comprehensive strategic plan and the ultimate realization of improved outcomes for young children and their families. The Department of Health and Human Services has recently been notified that this project has been funded.

**Source:** ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services, 2003.

**The Integrated Care Coordination Units (ICCU)** were developed and implemented to effectively manage at the local level the care of Nebraska children and families with multiple and complex needs. The program is designed to produce better outcome results in the lives of the children and families served at a cost savings to the State.

Region III Behavioral Health Services (Region III) has an agreement with the Nebraska Department of Health and Human Services (HHS) to form a collaborative partnership between Region III and the Central Service Area, Office of Protection and Safety. Consequently, ICCU was developed to care for youth who have complex needs and are state wards in Central Nebraska. The identified youth exhibit high functional impairments in multiple areas (e.g., school, home, community, self-harm, substance abuse) over a long period of time. These youth have multiple agency involvement, high service costs (although they constitute 25% of the state ward population in Central Nebraska they use almost 70% of the resources), and in which traditional services have failed to produce positive outcomes for these youth.

ICCU Care Coordinators provide intensive case management and ensure that care adheres to the principles of wraparound. Wraparound is a strengths-based process for services and supports that is individualized and based on the needs of the youth and his/her family. Care Coordinators from both HHS and Region III are trained in the areas of Protection and Safety and Wraparound. ICCU is a truly integrated model, bringing together the delivery of child welfare and juvenile justice services through intensive case management and the Wraparound process.

ICCU was implemented in January of 2001 with 20 Care Coordinators and began serving 201 identified youth who were enrolled in the unit between May and September 2001. The desired average caseload of the ICCU Care Coordinators is 10 families. Through March 2003, the ICCU has served 368 children and their families with seven youth having been enrolled in the program twice.

In addition to the successful implementation of the pilot project in Region III Lancaster County, Integrated Care Coordination has been provided through a contract with Families First and Foremost. The Nebraska Department of Health and Human Services contracted with Lancaster County to administer a seven million dollar federal grant to establish a comprehensive system of mental health and other support services for youth with serious emotional disorders who are in, or at risk of entering, the juvenile justice system. Both systems have a long and continuous record of support for children's mental health issues. The system of care established through this partnership has built upon the strengths of the community's diverse cultures and families. Through contracts with the Asian Community and Cultural Center, Faces of the Middle East, Indian Community Center and the Lancaster County Hispanic Center, our clients are receiving services that build upon their beliefs, customs and strengths in their communities and by professionals who share those beliefs and customs and identify with their ethnicity.

After the two pilot projects were implemented, Behavioral Health Regions 1, 4 and 6 partnered with Health and Human Services, Office of Protection and Safety to implement Integrated Care Coordination in their respective catchment areas. In various stages of implementation, these projects are also intended to serve the population of state wards with complex needs using wraparound principles. As these projects have just begun serving children, data is not available on number served or county penetration. We anticipate that by fall 2003, nearly 900 youth with serious emotional disorders will be served through five ICCUs across the State.

All of the Integrated Care Coordination Units will be gathering outcome data, and data on wraparound fidelity to assure adherence to wraparound principles.

We support continued efforts to integrate systems to better meet children's needs.

## **SECTION III – STATE PLAN:**

### **CHILDREN’S SECTION**

#### **CHILD STATE PLAN (FIVE CRITERIA)**

##### **Criterion 1: Comprehensive Community- based Mental Health Service Systems**

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services, and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services
  - Housing Services
  - Educational Services
  - Substance Abuse Services
  - Medical and dental services
  - Support services
  - Services provided by local school systems under the Individuals with Disabilities Education Act;
  - Case management services; and
  - Other activities leading to reduction of hospitalization.

##### **Organized community based system of care**

###### **Regional Systems of Care**

As a part of the six regional behavioral health systems in Nebraska, each Regional Youth Specialist take the lead in pursuing the development of a **comprehensive system of care for children and families** within each Region. Each system should include an array of effective services provided by highly trained staff, individualized care and coordination of services through a wraparound approach, families as equal partners at all levels, service provision and system design which is culturally competent, and an integrated service delivery system across mental health, education, child welfare, juvenile justice, and substance abuse services. This is provided through a community-state partnership. Youth specialists work to effectively manage the system to produce positive outcomes for children and families in a cost effective manner.

###### **Available System of Treatment and Support Services Purchased**

At the present time, funding sources purchasing mental health services for children and adolescents are administered through the Nebraska Health and Human Services system. The Health and Human Services is administered by three agencies (Services, Finance and Support, and Regulation and Licensure) that are coordinated through the HHSS Policy Cabinet. The Department of Health and Human Services (HHS), Division of Behavioral Health is the Mental Health Authority for Nebraska and administers state and federal mental health block grant dollars through six regional mental health/substance abuse administrations that are county operated. The HHS Division of Protection and Safety is the combined child welfare/juvenile justice authority for the State and works closely with the Behavioral Health Division and Mental Health Regions to address the needs of children and

adolescents with serious emotional disorders, who are wards of the state, and their families. The Medicaid Division is within HHS-Finance and Support and coordinates with the HHS Behavioral Health Division to administer Medicaid funding for child and family mental health. An Administrative Services Organization (Magellan) assists both agencies in utilization management, claims payment, and data collection for the public (Medicaid and non-Medicaid) behavioral health system. The Nebraska Department of Education administers state and federal education funding and has collaborated with the HHS Behavioral Health Division on school-based mental health services, early childhood mental health programs and vocational services for transitioning youth.

**Funding Pathways for services** Currently, federal block grant and state mental health dollars are administered through Health and Human Services, Office of Mental Health, Substance Abuse and Addiction Services via the six behavioral health regions. The Medicaid managed care program is administered by an administrative services only contract with Magellan Behavioral Health. Child welfare/juvenile justice funding is administered through the Department's Protection and Safety Division and local Health and Human Services Offices.

### **Mental Health Treatment and Rehabilitation Services Provided:**

<b>Public System</b>	<b>Medicaid EPSDT</b>	<b>Child Welfare/Juvenile Justice</b>
Mental Health Treatment: <ul style="list-style-type: none"> <li>• Outpatient Therapy</li> <li>• School Wraparound</li> <li>• Professional Partner Program</li> <li>• Day Treatment</li> <li>• Home-Based Services</li> <li>• Therapeutic Foster Care</li> <li>• Respite Care</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient Mental Health Treatment</li> <li>• Treatment Crisis Intervention</li> <li>• Day Treatment</li> <li>• Treatment Foster Care</li> <li>• Treatment Group Home</li> <li>• Residential Treatment</li> <li>• Inpatient Hospital Services</li> <li>• Enhanced Treatment Group Home</li> </ul>	<ul style="list-style-type: none"> <li>• Early Care and Education</li> <li>• Parent Education</li> <li>• Family Support Groups</li> <li>• Home-Based Support</li> <li>• Intensive Family Preservation</li> <li>• Home-Based Therapy</li> <li>• Non-Home Based Therapy</li> <li>• Respite Care</li> <li>• Emergency Shelter Care</li> <li>• Foster Care</li> <li>• Group Care</li> <li>• Community-Based Evaluation</li> <li>• Tracker Services</li> <li>• Day/Evening Reporting Programs</li> <li>• Support/Wraparound Services</li> <li>• Residential Evaluation</li> <li>• Electronic Monitoring</li> <li>• Youth Rehabilitation and Treatment Centers</li> <li>• Case Management</li> </ul>

Services for children and their families funded with public mental health dollars include specialized inpatient (including treatment for high risk sex offenders), outpatient services, and community-based middle intensity services including day treatment, school wraparound (formerly call therapeutic consultation), professional partners, home-based services, respite care, and therapeutic foster care. Service descriptions are as follows:

**Outpatient** - a specialized mental health treatment program for individuals experiencing a wide range of mental health problems causing disruption in the individual's life. Outpatient services are generally provided in sessions of less than three hours, on an individual, family,

or group basis. The program provides an appropriate assessment and/or diagnosis of the mental health problem, as well as effective treatment to change behaviors, modify thought patterns, cope with problems, and improve functioning.

**School Wraparound** (formerly called therapeutic consultation)- an organized intervention between a mental health program and a local school to provide consultation to school personnel and mental health services to the identified youth.

**Professional Partner Program** - a wraparound approach currently targeted to youth with serious emotional and behavioral problems who are at risk of 1) becoming a state ward to access services, 2) being placed out of home, 3) becoming involved in the juvenile justice system, or 4) dropping out of school. The service coordinates a strength-based assessment, develops an Individual/Family Services Plan through a multi-disciplinary team, purchases or coordinates formal and informal supports, and monitors service delivery and outcomes.

**Day Treatment** - an intensive, non-residential service that provides an integration of educational and mental health services. Day treatment programs typically consist of the following components: special education, counseling (individual or group), family services including parent training, vocational training, crisis intervention, skill building, behavior modification, and recreational therapy.

### **Substance abuse treatment services:**

Medicaid provides funding for Substance Abuse Treatment Services for youth who are eligible, including youth with a dual diagnosis. The Nebraska Medicaid office is in the process of rewriting service definitions to be more reflective of Substance Abuse treatment purchased by Medicaid. The following substance abuse service definitions are recognized through the Nebraska Behavioral Health system as eligible for funding from the public system within the behavioral health regions. Not all services are funded within each Region. Services are provided as funds are available.

**Youth Community Support**-The Community Support Program is for youth with an Axis I Substance Abuse Diagnosis or a Dual Disorder Diagnosis with a Primary Substance Abuse Disorder. Community Support is designed to assist substance abusing youth and their families to recognize substance abuse problems, and provide/develop the necessary services and supports which enable youth to live in the community with their natural family, foster parents or adoptive parents in a lifestyle free from substance abuse. The program should provide the youth with the ability to maximize quality of life in a substance free manner including participation in school and community. Community support staff will facilitate communication and coordination between multiple service providers that serve the same youth, including the school and educate and support parents to meet the specialized needs of the substance abusing youth. Community support provides youth advocacy, ensures continuity of care, and supports youth and their families in time of crisis. Staff will provide and procure youth and parent skill training in dealing with substance abuse and related issues, ensures the acquisition of necessary resources and assist the youth in achieving community/school/ /vocational integration in a lifestyle free from substance abuse, in a developmentally appropriate manner. The community support program provides a clear locus of accountability for meeting youth and related family needs with the resources available within the community. The role of the community support worker may vary, and services are generally provided out of office in community locations consistent with individual youth need.

**Youth Partial Care** Partial Care Programs provide group-focused, non-residential services for substance abusing youth or dually diagnosed youth who require a more restrictive treatment environment than that provided by outpatient counseling, but do not require a residential program. Activities of this program must focus on aiding youth and their families in recognizing their

substance abuse problems, and assisting youth to develop knowledge and skills necessary for making lifestyle changes necessary to maintain a life free from substance abuse. Partial care staff will work cooperatively with the schools to support successful educational performance by the youth, documenting that educational services have been maintained while in care. Adequate professional structure to prevent immediate relapse must be provided. Partial care would average, at the minimum, 30 hours per week of structured activities and may include individual, family and group counseling services.

**Youth Therapeutic Community** Therapeutic Community programs provide long term comprehensive residential treatment for substance abusing or dually diagnosed youth for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance abuse on the youth's life or because of a history of repeated short term or less restrictive treatment experiences. These programs provide psychosocial skill building through a long term, highly structured set of peer oriented treatment which define progress toward individual change and rehabilitation. Activities are developmentally appropriate for youth, and incorporate a series of defined phases. The program is staffed on a 24 hour basis, and has access to on call medical personnel. Youth educational needs may be met on site.

**Youth Short Term Residential** Short Term Residential programs provide highly structured (24) hour comprehensive services for substance abusing youth or dually diagnosed youth who require a more restrictive treatment environment to prevent the use of abused substances. For a youth to be eligible for services, there must be documentation from a youth assessment that shows that there is no reasonable chance of maintaining youth in their family and educational environment during treatment. Activities of this program must provide daily structure to prevent access to abused substances. The program must focus on developmentally appropriate ways to develop the knowledge and skills necessary to maintain a life free from substance abuse. Short Term Residential services must be integrated into the continuum of a youth's care to allow youth to move from a residential to a less restrictive placement. The expected duration of treatment is no more than (45) days.

**Youth Halfway House** Youth Halfway House programs provide transitional residential treatment services for youth seeking to re-integrate into the community, generally after short term or intermediate residential treatment. These programs must provide a structured set of activities designed to develop the independent living skills necessary to remain free from substance abuse outside a residential treatment setting. They should assist the youth to return home or to access a temporary family home environment. The program must also focus on assisting youth to maintain educational involvement.

**Youth Intensive Outpatient** Intensive Outpatient provides group focused, non-residential services for substance abusing youths who require a more structured treatment environment than that provided by outpatient counseling, but who do not require a residential program. Activities must focus on aiding youth to recognize their substance abuse problems and to develop knowledge and skills for making lifestyle changes necessary to maintain a life free from substance abuse. It is a non-residential, facility based, multi-service program centered around group counseling services designed to stabilize and treat youth with moderate to severe substance abuse problems. Other services could include: 24 hour crisis management, individual counseling; education about AOD issues, family education and counseling, self help group and support group orientation.

**Youth Outpatient Therapy/Evaluation** Outpatient therapy is a specialized substance abuse program for youth experiencing a substance abuse problem that causes moderate and/or acute

disruptions in the youth's life. Outpatient programs provide individual, family, and group treatment services, generally on a regularly scheduled basis. The outpatient program provides to each youth served the appropriate assessment and/or diagnosis of the substance abuse problem, as well as effective treatment to change behaviors in order to attain and maintain a substance abuse free lifestyle. Programs may include collateral or adjunctive services. Adjunctive services are designed to link and coordinate other services necessary for the youth, in order to achieve successful outcomes. These services may include information gathering and reporting, coordination of services, referral facilitation, and related activities to assure coordination between programs.

**Assessment Only** Assessments are conducted by a Certified Alcohol/Drug Abuse Counselor to evaluate youth that exhibit behaviors which may be indicative of a substance abuse problem. Such an assessment would attempt to determine if a substance problem exists, the extent of the problem, identify biopsychosocial and other contributing factors, and recommend what, if any, treatment is needed. An assessment should specify youth strengths and weaknesses, which will aid in formulating a treatment plan. Standardized screening and assessment tools may be used when conducting a substance abuse evaluation.

### **Description of the State's Case Management System**

Children and adolescents with serious emotional disorders receive **case management** through the mental health programs that serve them. Regulations require that all mental health programs funded by the Department that serve children and adolescents have policies and procedures to ensure that families and youth with serious emotional disorders needs, are actively involved in treatment planning and have the skills necessary to support and maintain those treatment goals. Documentation on the service record must reflect the service recipient's treatment/rehabilitation needs and experience. The plan should be of the kind and quality to facilitate service planning, evaluation, and continuity of care. Those programs determine criteria for eligibility for case management.

### **Health Services:**

**Medical Services** may be provided through funds in the MATERNAL AND CHILD HEALTH BLOCK GRANT STATUTORY AUTHORITY: Chapter 21, Article 22, R.R.S., 1943. The administering agency is the Department of Health and Human Services/Finance and Support. Under Title V of the Social Security Act of 1935 as amended, Nebraska receives federal funding to address the health needs of all mothers and children, with particular responsibility towards low-income individuals or other populations with limited access to care. The projects provide services to low-income, high risk Group mothers and infants, to children and adolescents and to children with **chronic handicapping or disabling conditions**. The following services are provided through projects targeted for children and adolescents:

- prenatal education, home visits, health screening, direct care and follow-up to pregnant adolescents
- health screening, history, physical examinations, nutrition counseling and anticipatory guidance
- acute and chronic care
- preventative and simple intervention dental care
- mental health services
- immunizations
- access to Health Check services through Medicaid
- teen pregnancy prevention education and intervention
- nutrition education
- dental health and dental education services

**Dental Services** may be provided by the Dental Health Program, which provides comprehensive dental services for children who would not otherwise receive care because of economic or other reasons beyond their control. This program is funded by the Maternal and Child Health Block Grant. The Dental Health of Children Program serves school and preschool age children from low-income families who do not qualify for Medicaid. The Program serves as an entry point into the dental health delivery system for eligible children and to improve the quality of services necessary to prevent disease and restore and maintain oral health.

Project services include preventative services, examination and diagnosis, treatment, correction of defects, and aftercare.

In Nebraska, these programs located in rural areas are structured so as to utilize the services of private dental practitioners through contractual agreement. Four community action agencies in Richardson, Nemaha, Dakota and Red Willow counties determine client eligibility and refer eligible children to one of the approximately 30 contract dentists in 10 counties. This program serves approximately 300 children a year.

**Housing** and other **support needs** are addressed through referral to appropriate services. For youth diagnosed with a serious emotional disturbance who are at risk of being placed out-of-home, becoming a state ward, or committing a juvenile offense, **case management** is provided through the Professional Partner Program, funded by the Office of Mental Health, Substance Abuse and Addiction Services. This program includes strength-based assessment, treatment planning, brokering services, and monitoring plan implementation. Transition age youth with housing needs have been made a priority population within the Statewide Consumer Housing Need Study contract. Two Planning Council members representing families with SED children are members of that project advisory committee, as well as having been integrally involved in the contracting process.

**Prevocational/Employment services** for children with serious emotional disturbances are also provided through the public school system under the provision requiring **transition services**. The term transition services means a coordinated set of activities for a student with a disability that is designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; is based upon the individual student's needs, taking into account the student's preferences and interests; and includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

The Workforce Investment Act is the first major reform of America's Job Training System in fifteen years. It was signed into law by President Clinton on August 7th, 1998.

Key Components include:

- Streamlining Services - Programs and providers will co-locate, coordinate and integrate activities and information, creating a coherent and accessible one-Stop system for individuals and businesses.
- Empowering Individuals - Individual Training Accounts (ITA's) at qualified institutions will supplement financial aid from other sources and may pay for all the costs of training. A system of consumer reports will provide key information on the performance outcomes of training and education providers.
- Through ITA's, participants choose training based on program outcomes. To survive in

- the market, training providers must make accountability for performance a top priority.
- State and Local Flexibility - Significant authority is reserved for the Governor and chief local elected officials to implement an innovative and comprehensive workforce investment systems tailored to local and regional labor market needs.
- Improved Youth Programs  
Programs will be linked more closely to local labor market needs and community youth programs, with strong connections to academic and occupational learning.

"One-Stop" Centers serve as the cornerstone of the new Workforce Investment System. These Centers will unify training, education and employment programs into one customer-friendly system in each community. At least one full-service center will be located in each workforce investment area. Strategic Goals for Improved Youth Programs include:

- Nebraska parents, educators, businesses, and service providers work as partners in providing youth with opportunities for a lifelong learning environment to reflect the changing needs and skills of the workforce.
- School-to-Career efforts are strengthened and expanded in order to continually invest in our youth's future by coordinating partnerships between business, students, education, and communities.

How will the youth programs be enhanced and expanded so young people have the resources and skills they need to succeed in the state's economy?

Local areas will be encouraged to take advantage of the School-to-Work network and existing partnerships in their areas. Collaborative planning with the schools and School-to-Work partnerships should include: preparation of all youth for adulthood, successful careers and lifelong learning, in addition to strengthening basic skills. School-to-Work partnerships can assist local Workforce Investment boards and youth councils in providing continuity between Workforce Development and the education system.

#### One-Stop Services to Youth

The chief elected official, as the local grant recipient for the youth program, is a required One-Stop partner and is subject to the requirements that apply to such partners.

In addition, connections between the youth program and the One-Stop system will include those that facilitate:

1. The coordination and provision of youth activities;
2. Linkages to the job market and employers;
3. Access for eligible youth to the local youth program information and services; and (4) Other activities designed to achieve the purposes of the youth program and youth activities.

Local boards have the flexibility to offer services to area youth that are not eligible under the youth program through the One-Stop centers. However, One-Stop services for non-eligible youth must be funded by programs that are authorized to provide services to such youth. For example, basic labor exchange services under the Wagner-Peyser Act may be provided to any youth.

CORE MEASURES OF PERFORMANCE include:

## YOUTH AGE 19-21

Entry into unsubsidized employment

6-months retention in unsubsidized employment

6-months earnings received in unsubsidized employment

Attainment of educational or occupational skills credential

## YOUTH AGE 14-18

Attainment of basic, work readiness, and/or occupational skills

Attainment of secondary school diplomas/equivalents

Placement and retention in post-secondary education/training, or placement in military, employment, apprenticeships.

Following is information on the Cooperative agreement for S.U.C.C.E.S.S.  
(Students Utilizing the Cooperation of Community Employment and Schools for Success)

Additionally, Grand Island Senior High School (CNSSP), Region III Behavioral Health Services and NE Vocational Rehabilitation have been in partnership since September, 1999 to provide services to students ages 14-21 who are eligible for V.R. Services, Professional Partners and are served by GIHS. The targeted population are:

1. Students who are considered to be at risk in the community, school or workplace.
2. Students who are verified with disabilities (SPED or 504 eligible).
3. Students who are considered candidates for competitive employment.
4. Students who must exhibit a serious emotional disorder.

In addition to funding, Region B.H. III services include professional partner service, building informal supports, mental health assessment and related needs, crisis plan development & Wraparound services. Grand Island HS services include the funding contribution, Special Ed Assessment, IEP development, facilities, networking, academic/educational services and structural and systemic accommodation. VR services besides funding include vocational assessment and counseling, job placement, job seeking skills and job retention counseling and employment related independent living skills. Services provided with cooperative funding include job coaching, job specific training, required tools, clothing, on the job training, mentoring, Transportation and miscellaneous individual accommodations necessary to employment success.

For the past four (4) years, the average number of students served each year is 8. The average age of the students have been 16 and have had a variety of Behavioral Health disorders. Each student has had professional partner and wraparound services, educational accommodations. The vocational services have included job site placement and vocational counseling. Some have started in unpaid work experiences and others in regular competitive employment. This past year VR provided a weekly group focused on job keeping skills.

This program has been extended each year, still using the original "pot" of money. The collaboration between the agencies has kept the expenditures to only what the student needs to be successful in a job placement. The partners meet monthly to review progress on students and to process new referrals.

Another program for improving employment opportunities for youth is SCOPE. SCOPE is an acronym for STUDENT CAREER OPPORTUNITIES IN PERMANENT EMPLOYMENT. This is

a cooperative agreement between the Lincoln Public Schools and Voc Rehab that focuses on special education students in their last year of high school classified as either having a learning disability (SLD) or behavioral disorders (BD). These are two special education groups for which LPS has not provided employment related services to. For most of the students who participate, SCOPE places them in their first every job, provides job coaching and follow along. Approximately half of the students end up losing or quitting their job and require services again prior to or after exiting school. It is a small program as this last year it served 18 students. (for other employment, see Criteria #3).

Alternatives to Long Term Care Efforts to further reduce the need for long term care for youth focus on the expansion of community alternatives. The Department has historically attempted to expand, and, more recently, maintain funding for needed community mental health services for children and adolescents with serious emotional disorders, including:

- Professional Partner and other middle intensity health services
- Comprehensive Community Services grants;
- Building resources around Vocational Rehabilitation/Career education opportunities for adolescents with serious emotional disturbances
- Integrated care coordination projects using wraparound for ensuring coordinated care for children in the child welfare and juvenile justice system
- Custody relinquishment in order for children to access mental health services.

### **Educational Services: see Criteria #3**

**Family Support Organizations** Another component of the service array system in the community is the family support organizations in each of the six behavioral health regions. The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services offered a proposal to solicit bids for a new support activity called **“Families Mentoring & Supporting Other Families”**, a joint initiative to request proposals from qualified sources to provide:

1. Strength-based, family centered, and partnership oriented supports to:
  - a) parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or
  - b) parent who are involved with the department as a result of a report of abuse/neglect, or
  - c) parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders.
2. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The Department sought to find an organization interested in working with the State to build support services to families that will focus on providing parents with an understanding of wraparound services through peer role modeling and coaching. The philosophy of wraparound includes individualized services that are developed through professionals and parents in partnership where both are serving important roles in service delivery. Services are tailored to meet the individualized needs of the child and family and based upon strength-based assessments.

Nebraska Federation for Families, in conjunction with the two children’s mental health grants, has worked on legislative and policy initiatives to prevent families from needing to make their children state wards in order to access services. The Department has accessed technical assistance to help them in this initiative.

<b>GOAL #1:</b>	Maintain capacity of Professional Partner (wraparound) program for children with serious emotional disturbance.
<b>POPULATION:</b>	Children and adolescents with serious emotional and behavioral disorders

<b>OBJECTIVE:</b>	The number of children participating in Professional Partner wraparound program will be maintained.			
<b>CRITERION:</b>	#1 Comprehensive, community-based mental health system			
<b>BRIEF NAME:</b>	Children enrolled in Professional Partner			
<b>INDICATOR:</b>	The number of children participating in Professional Partner services			
<b>MEASURE:</b>	Count of number of children participating in Professional Partners as of June 30 of each year.			
<b>SOURCE OF INFORMATION:</b>	Magellan Behavioral Health			
<b>Performance Indicator</b>	<b>3. FY 2002 Actual</b>	<b>FY 2003 Actual</b>	<b>FY 2004 Objective</b>	<b>% Attain</b>
Children in Professional Partner	365	644	644	

**Criterion 2: Mental Health System Data Epidemiology**

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion one (1).

**YOUTH**

Estimated Number of Children and Adolescents, Age 9 to 17,  
with Serious Emotional Disturbance (SED), 2000

Number of Youth 9-17	Percent in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit
235,365	12.33	11,768	16,476	21,183	25,890

Col 1: Number of Youth 9 – 17      23,537 = NE estimated SED

Col 2: % of Youth in Poverty

Level of Functioning= or less than 50

Col 3: Lower Limit of Estimate

Col 4: Upper Limit of Estimate

Level of Functioning= or less than 60 (Official Estimate)

Col 5: Lower Limit of Estimate

Col 6: Upper Limit of Estimate

Source:[Data\_Infrastructure\_Grants] Updated Table 1 Information

Information on prevalence estimates for SMI and SED.

U.S. Department of Health & Human Services, Center for Mental Health Services (CMHS)

Nebraska is engaging in a number of activities to expand service delivery to serve more children and adolescents with serious emotional and behavioral disorders including the following:

- Provide an array of services to the highest need youth in the all areas of the Protection and Safety system

- Refine a system of telehealth which will improve access to mental health care for all youth (and adults) experiencing a behavioral health emergency
- Continue to conduct point-in-time survey to analyze and target resources to better meet the mental health and substance abuse needs of state wards
- Conduct needs assessment in each mental health region identifying the services available, gaps in services, and priorities for service development

Regarding census data, see Adult Criteria 2.

AGE - Under 18 years 450,242

Source: Nebraska Databook, Last Updated on 2/26/02 <http://info.neded.org/stathand/bsect8.htm>  
based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001.

<b>GOAL #2:</b>	To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System.			
<b>POPULATION:</b>	Children and adolescents receiving Mental Health Services			
<b>OBJECTIVE:</b>	The number of children receiving services will be maintained			
<b>CRITERION:</b>	#1 Comprehensive, community-based mental health system			
<b>BRIEF NAME:</b>	Persons age 0-17 receiving services			
<b>INDICATOR:</b>	The number of children receiving services			
<b>MEASURE:</b>	Count of number of children receiving services			
<b>SOURCE OF INFORMATION:</b>	Magellan information management system			
<b>1. Performance Indicator</b>	<b>3. FY 2002 Actual</b>	<b>FY 2003 Actual</b>	<b>FY 2004 Objective</b>	<b>% Attain</b>
Children receiving services	2257	2765	2765	

### PENETRATION/UTILIZATION RATES

Federal Estimated number of youth in Nebraska with Severe Emotional Disturbance	<b>23,537</b>
Total number of youth served by NBHS in FY 2003	2765
Total number of youth with SED served by NBHS in FY 2003	666

Demographic Overview of Children (age 0-17) with SED served in Nebraska Mental Health System:  
The FY2003 data were not available at the time of completing this document.

<b>Magellan Behavioral Health SED Persons Served FY2001 and FY 2002</b>				
	<b>FY2001</b>		<b>FY2002</b>	
	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>
<b>Total Children with SED served</b>	2734		2,257	
<b>By Region:</b>	2,562	100%	2,257	100%
Region 1	103	4.02%	66	2.92%
Region 2	141	5.50%	125	5.54%
Region 3	433	16.90%	332	14.71%
Region 4	178	6.95%	181	8.02%
Region 5	1,335	52.11%	1,231	54.54%
Region 6	350	13.66%	311	13.78%
Unknown	22	0.86%	11	0.49%
<b>By Age:</b>	2,562	100%	2,257	100%
Under 10	703	27.44%	647	28.67%
10 – 14 years	919	35.87%	856	37.93%
15 – 17 years	940	36.69%	754	33.41%
<b>By Gender:</b>	2,562	100%	2,257	100%
Male	1,359	53.04%	1,171	51.88%
Female	1,198	46.76%	1,085	48.07%
Unknown	5	0.20%	1	0.09%
<b>By Race:</b>	2,562	100%	2,257	100%
White	2,213	86.38%	1,923	85.20%
Black/African American	105	4.10%	115	5.10%
American Indian	71	2.77%	56	2.48%
Asian/Pacific Islander	18	0.70%	11	0.49%
Alaskan Native	3	0.12%	2	0.09%
Other	127	4.96%	114	5.05%
Unknown	25	0.98%	36	1.60%
<b>By Ethnicity</b>	2,562	100%	2,257	100%
Puerto Rican	0	0.00%	2	0.09%
Mexican	62	2.42%	66	2.92%
Cuban	0	0.00%	0	0.00%
Other Hispanic	79	3.08%	67	2.97%
Not Hispanic	2,369	92.47%	2085	92.38%
Unknown	52	2.03%	37	1.64%

**Criterion 3: Children's Services**

- Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
  - Social services,
  - Education services, including services provided under the Individuals with Disabilities Education Act;
  - Juvenile justice services,
  - Substance abuse services, and
  - Health and mental health services
- Establishes defined geographic area for the provision of the services of such system.

**State Level Departmental Systems** At the state level, the Public non-Medicaid behavioral health system is administered by the Office of Mental Health, Substance Abuse and Addiction Services within the Department of Health and Human Services. Medicaid and the State Children's Health Insurance Program (Kid's Connection) is administered by the Medicaid Division of the Department of Health and Human Services Finance and Support. The child welfare and juvenile justice system is integrated and administered through the Protection and Safety Division of the Department of Health and Human Services. Education and Special Education are administered by the Department of Education.

**Service Integration and Collaboration Efforts** The Mental Health Office and the Protection and Safety Division worked together on areas of mutual interest. Some of these areas have included developing parameters for systems of care, identifying behavioral health assessment devices to use in the HHS Protection & Safety System (Child Welfare/Social Services Department in Nebraska), developing integrated care coordination at the local level), developing wraparound training standards, and participating in Nebraska Family Portrait (planning effort for child welfare and juvenile justice). Collaboration with the Department of Education includes joint funding and development of school wraparound programs and a major initiative to address the mental health needs of young children and their families.

**Substance Abuse Services (see criteria #1)****Education Services**

Students diagnosed with a severe emotional disturbance qualify for special education services within the public school system. All students qualified for special education and related services under the Individuals with Disabilities Education Act (IDEA) and Nebraska's 92 NAC 51.

School districts are required to insure that all children with verified disabilities, from date of diagnosis to age 21, have available to them a free appropriate public education which includes special education and related services to meet their unique needs. The Department of Education is responsible for establishing the standards for special education programs, reviewing programs and providing financial assistance. Children with disabilities must be verified in one or more of the following categories to receive special education:

- |                            |                           |                                  |
|----------------------------|---------------------------|----------------------------------|
| - behavioral disorder      | - mental handicap/sever-  | - specific learning disabilities |
| - deaf/blindness           | profound                  | - speech-language impairment     |
| - hearing impairment       | - multiple disabilities   | - visual impairment              |
| - mental handicap/mild     | - orthopedic impairment   | - traumatic brain injury         |
| - mental handicap/moderate | - other health impairment | - autism                         |

Participation of children with a verified disability under age five is voluntary.. Resident non-public students with a verified disability must be given the opportunity to participate in special education and related services. Special education services may be provided by any agency authorized by the Nebraska Department of Education to provide special education services. Special education programs are administratively organized as Early Childhood Special Education and as School Age Programs.

Early Childhood Education Services include all special education and related services for children with verified disabilities from birth to age five. Services coordination for infants and toddlers with disabilities below age three is jointly administered by the Department of Health and Human Services and the Department of Education.- Programs for children with disabilities of school age are organized by levels.

- Level I special education support services are those special education services provided to students who require an aggregate of not more than three hours of such services per week. Level I special education support services include all administrative, diagnostic, consultative and vocational adjustment counselor services.
- Level I and Level II combination special education services shall mean those special education programs which serve both Level I and Level II students in a combined program.
- Level II special education services are those special education and related services which are provided outside of the regular class program for a period of time exceeding an aggregate of three hours per week.
- Level III special education contractual services are those special education and related services provided in an educational setting not operated by the resident school district whose rates are approved by the Department of Education.

Before any action is taken with respect to the initial placement of a child with a disability, the school district or approved cooperative shall be responsible for the provision of a comprehensive individual multi-disciplinary evaluation of the child's education and developmental needs.. The school districts establish policies and procedures to assure that, to the maximum extent appropriate, children with disabilities are educated with children who do not have disabilities and that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. Each school district or approved cooperative shall assure an array of special education placement options are available. Those options shall include instruction in regular classes; supplemental services such as resource room, itinerant instruction or consultative services to be provided in conjunction with regular class placement; special classes; special schools; home instruction and instruction in hospitals and institutions. . Educational placement of each child with a verified disability:

- is determined at least annually
- is based on his/her individual education program or individual family service plan for infants and toddlers below age three
- is as close as possible to the child's home

Educational needs of students diagnosed with a severe emotional disturbance will be met in the least restrictive environment. Prior to verification for special education services, students and their parents will meet with teachers, administrators and other related staff to determine student needs and how best to meet them. Often times, in Nebraska, the family may be accompanied by a **Professional Partner**, a professional trained in wraparound services, to assist the team in finding innovative solutions for assisting teachers to meet needs and allow students to remain in the regular classrooms. Tutoring and mentoring services are often provided to assist in these efforts. However, wraparound may include any innovative solution proposed and approved by the team and is not limited to a finite

list of services. Other times, parents may be accompanied by other parents of SED children as part of the **family organization's** efforts to provide advocacy for students and their families. Students are eligible to receive supplementary aids and services and support services.

Should the student's educational needs not be met by the above efforts, the resident school district shall conduct a full and individual initial evaluation for each child being considered for special education and related services before the initial provision of special education and related services to a child with a disability. Services may be provided as described below:

Services shall mean transportation and such corrective, developmental, and other supportive services as required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, parent counseling and training, and orientation and mobility services.

Assistive technology service means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device. The term includes the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by a child with a disability; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with a disability, or if appropriate, that child's family; and training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the individual with a disability.

**Developmental of Local Systems of Care** Public non-Medicaid behavioral health services are administered at the local level by the six mental health regions, which are county operated. Efforts to develop local systems of care focus on two Center for Mental Health Services Comprehensive Children's Grants. The Department of Health and Human Services in conjunction with the Nebraska Department of Education and Region III Mental Health Administration received a Comprehensive Community Services grant designed to establish an integrated system of care in 22 central Nebraska counties. In addition, the Department in conjunction with Region V Behavioral Health and Lancaster County have received a second grant which focuses on the developing a comprehensive system of integrated care to address the mental health needs of youth in the juvenile justice system. In each mental health region, Youth Specialists are working to achieve the following goals:

- Assessing the behavioral health needs of children and their families in the region and identifying gaps in services
- Developing and implementing strategies for development of an array of effective behavioral health and related services
- Developing strategies to ensure services are coordinated and care is individualized
- Developing strategies to ensure parents and other family members of children in services are equal partners at all levels
- Developing strategies to ensure service provision and system design are culturally competent

- Developing strategies for integration of service delivery and resources across mental health, substance abuse, child welfare, juvenile justice, and education
- Developing strategies to effectively manage care to produce positive outcomes for children and families in a cost effective manner

### **Juvenile Justice**

A new funding initiative is the Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) Federal Grant. VOI/TIS funding is offered by the federal government to assist states in addressing issues of violent offenders and overcrowding in their juvenile correctional facilities. Nebraska was awarded VOIT/TIS funding in the amount of approximately \$4 million to increase bed capacity for violent juvenile offenders and to address issues of overcrowding in the Youth Rehabilitation and Treatment Center (YRTC) in Kearney. Nebraska is required to provide a 10% match. Nebraska identified two specific services to assist the YRTC in Kearney to address their overcrowding. HHS/OJS and the facility are working to implement and operationalize these two programs at the present time. One program being established is a sexual offender program, and the other is a culturally sensitive transitional program for African-American youth. All youth referred to either of these programs will remain committed to the YRTC-K, but be served at a site other than the main campus. The alternative site programs will be self-contained and offer specialized services to meet the behavioral, emotional, and physical needs of these particular youth.

The Sexual Offender Program will be located in Lincoln and will be able to serve approximately 7-9 male juveniles. Youth in this program will have significant functional impairments due to emotional disorders, as well as cognitive and/or sexual behavioral impairments. They will have persistent patterns of disruptive behavior and disturbance in age-appropriate adaptive functioning, and be at very high risk for causing harm to self or others. Youth will receive specialized services to address their sexual offender issues and other issues impacting their daily functioning.

The Transitional Living Program will be located in Omaha and will be able to provide culturally sensitive alternative programming for 8-10 African-American juvenile males instead of traditional programming at YRTC-Kearney. This program will concentrate on teaching these youth viable independent living skills for success in the future and to divert them from any future delinquent behaviors. Youth in this program will also have significant functional impairments due to emotional disorders and possibly have cognitive impairments. They will have persistent patterns of disruptive behaviors, disturbance in age-appropriate adaptive functioning, and be at risk for causing harm to self or others. In addition, they will receive services to improve upon their lack of vocational, interpersonal, and social skills generally considered necessary to live in the mainstream of society and be drug-free, free of criminal behavior, and legitimately successful. Offering such a culturally sensitive program will also enable the department to begin to address the issue of disproportionate minority confinement (DMC). Although these programs offer exciting opportunities for youth targeted to be served, they are reactive in nature as youth must be in the juvenile justice system to participate. It is our hope that a less reactive, more proactive approach can be added to the service array to intervene before crisis occurs.

**Juvenile Justice/Employment** (also see criteria #1) The JUST WORK (JUVENILES UTILIZING STRUCTURE TO WORK) partnership is a cooperative agreement between Nebraska Vocational Rehabilitation and Nebraska Health and Human Services (Office of Juvenile Services and the Status Offense Unit). The jointly funded and federally matched agreement began in April, 1998 to provide vocational rehabilitation services for adjudicated youth in the Juvenile Justice System. Research had shown that many of the Juvenile Services youth experienced a diagnosed mental illness or chemical dependency which would make them eligible to receive Vocational Rehabilitation services. It was

agreed between the agencies to co-fund a program that would give the adjudicated youth an opportunity to increase their chances to become successful adults. The services provided to the youth include vocational assessment, vocational planning, vocational counseling, employment readiness training, job placement, job follow-up, and job maintenance services. The program also offers an Extended Employment warranty program that allows the youth to return to the program to upgrade their employment opportunities. Most of the youth served are between 15 – 18 years old so one of the goals of the partnership is to provide employment opportunities to the youth so that they can become successful adults in the community. It is much more cost effective to provide these low cost community services than to pay for continued institutionalization.

Approximately 80% of the youth served in this program have a diagnosed mental illness or chemical dependency. They also require multiple services that need to be coordinated between several agencies. This is possible by co-locating the service providers and making it easy for the youth to access the services.

All the agencies involved in this partnership are very pleased with the outcomes that have been achieved. The partnership has an on-site GED program that has successfully graduated over 30 students since October, 2001. As stated earlier, competitive employment is the overall goal for the program participants. Since April, 1998, approximately 210 youth have successfully completed the program and were working successfully in the community. Many more youth are still participating in the program and in time will become successful adults in the community.

**Integrated Care Coordination** One of the key initiatives in system of care development is the Integrated Care Coordination Project. During FY 2001, the Department of Health and Human Services in partnership with Region III Behavioral Services developed a proposal to integrate care for children in the child welfare/juvenile justice system. Integrated care coordination is designed to effectively manage the care of children and families with multiple and complex needs at the local level. The initiative is designed to serve 201 high-need children in Central Nebraska who are wards of the state. The youth are those in Agency-Based Foster Care (therapeutic foster care) and higher levels of care. Funding is through a case rate based on 95% of the cost of serving these youth during FY00. This project utilizes an integrated care coordination collaborative that includes Protection and Safety Workers (child welfare and juvenile justice system), Professional Partners (mental health and substance abuse service system), School-Based Wraparound Teams (education system), Families CARE Partners (family members partner with public system care coordinators to provide additional support and advocacy for families served in the program), and Community Wraparound Teams (teams that identify and support a wraparound team to assist children and families in need. The team mobilizes informal supports that remain with the child and family far beyond the time formal services are discontinued).

Each child has access to a comprehensive array of services through Behavioral Health Resources, a provider network of 11 behavioral health organizations that offers 32 core services. Other important system components include Families CARE, a family operated support and advocacy organization for families of children with serious emotional and behavioral issues, Community Teams that provide early intervention and coordinate local resources throughout Central Nebraska. The Department of Health and Human Services/Region III integrated Care Management Team provides utilization management/review, a strong cross agency process to formulate recommendations regarding appropriate levels of care, and an evaluation component that utilizes demographic information, service utilization, cost, and outcome data to inform decision making around service delivery and system improvements.

**Cultural Competence within the System of Care** Nebraska Family Central is conducting strategic planning and program evaluation regarding cultural competence for the system of care. Components that are measured include:

- Family Perception of cultural competency
- Analysis of demographics of service population as compared to the general population to examine systemic cultural biases.
- Ensure cultural competence training for providers
- Assess the cultural and demographics of providers (staff) to ensure that staff reflect the demographics of consumers

**Health and Mental Health Services: see Criteria #1**

**GOAL #3:** To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs

**POPULATION:** Children with serious emotional disorders who are wards of the state

**OBJECTIVE:** The number of children who are in the custody of the state and who receive integrated care coordination will increase by 5%.

**CRITERION:** Children's Services

**BRIEF NAME:** Integrated care coordination for state wards with SED

**INDICATOR:** The number of children receiving integrated care coordination

**MEASURE:** Count of children receiving integrated care coordination

**SOURCE OF INFORMATION:** Program evaluation reports

**SIGNIFICANCE:** Emerging body of research indicates intensive case management using the wraparound approach can be effective in ensuring appropriate services and reducing expenses of using high cost services

1. Performance Indicator	2. FY 2002 Actual	3. FY 2003 Actual	FY 2004 Objective	% Attain
Number of wards in ICC	222	457	500	

**Criterion 4: Targeted Services to Rural and Homeless Populations**

- Describes states' outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals residing in rural areas.

**Outreach to the Homeless Population** The Department receives PATH block grant funds from the Alcohol, Drug Abuse, and Mental Health Administration of the Federal Department of Health and Human Services to provide services to individuals who are homeless and mentally ill. The Department contracts with Regions I, II, III, V and VI Governing Boards, which subcontract with mental health providers for PATH grant services. The projects provide outreach, screening, and diagnostic treatment services, staff training, case management, support services in residential settings, referral, and other appropriate services to individuals identified as mentally ill and homeless. In addition, formal training presentations are made to staff concerning the needs of homeless emotionally disturbed persons. Case managers may facilitate the acquisition of income support, housing, and social services where feasible.

Children's mental health service providers are encouraged to collaborate with runaway and homeless shelters across the state. In fact many of the local provider networks in the Mental Health Regions have included shelters as part of the formal network. The Comprehensive Community Services Grant provides a laboratory to develop a system of outreach for runaway and homeless youth in

central Nebraska. The shelter in central Nebraska is an integral part of the provider network in that region.

**Rural School Based Wraparound** One of the most effective efforts at serving children with serious emotional disorders in rural areas of the state has been the development of school-based wraparound. A major issue with many wraparound-planning efforts involves the intersection of the community, social service providers, and the schools. One of the most difficult problems is engaging school personnel to become full partners in the wraparound process. Developing a school-based support plan, as part of an overall wraparound plan is often complex due to language and system barriers between schools and other child and family team members. The wraparound approach must include improved academic performance as well as behavioral functioning for children. Rural school wraparound services are provided in Regions I, III and IV.

The goals of this program are to eliminate or greatly reduce the frequency and intensity of the youth's referral behavior, empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school and neighborhood issues. The program also strives to develop a network of informal supports to help sustain the child and family when formal services are no longer needed. Finally, utilizing the wraparound approach the program hopes to reduce negative consequences for the child including out-of-home placements, juvenile justice involvement, and school failure, while enhancing positive outcomes including improved school performance and successful transition to adult living and employment.

**Ensuring services to children in rural areas** There are six counties in Nebraska designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. Using the Census Population as of April 1, 2000 for these "Metropolitan Statistical Areas", the Nebraska portion of the "Omaha, NE--IA MSA" includes Cass County (24,334), Douglas County (463,585), Sarpy County (122,595), and Washington County (18,780); the Lincoln, NE MSA contains Lancaster County (250,291); and the Nebraska portion of the Sioux City, IA--NE MSA is Dakota County (20,253). In April 2000, these six "Metropolitan Statistical Areas" counties had 899,838 people, accounting for 52.6% of the State of Nebraska population (1,711,263).

Numerator = At time of admission, Total Children with Who Received Community Mental Health Services with a "County of Residence" (Magellan field # 15) outside of Douglas, Lancaster, Sarpy, Washington, Cass, and Dakota counties.

- exclude: Cass County, Douglas County, Sarpy County, Washington County, Lancaster County and Dakota County.
- include: 87 remaining Nebraska counties.

**Data source: from Magellan Behavioral Health Information System, as under contract with NE HHS/ Office of Mental Health, Substance Abuse, and Addiction Services.**

Additionally, services are provided to rural children through the Rural Mental Health Crisis voucher program. The Rural Mental Health Program provides hotline and crisis counseling services to the rural residents of Nebraska. The demand for these services continues to increase as those who derive their livelihood from the rural economy continue to face the stress of low prices, increased costs, and drought.

The program suits rural residents because it is simple to access, involves minimal paperwork, and is less intrusive to recipients receiving counseling vouchers. Rural residents call the hotline to request vouchers and receive counseling.

Persons calling the toll-free Nebraska Farm Hotline who present to be in need of professional mental health treatment are informed of the “Voucher Program”. The “Voucher Program” is designed to make cost-free, confidential mental health counseling available to persons affected by the current rural crisis. The program is not limited to farmers. Any rural person who is negatively impacted by the rural crisis may apply. This includes farm family members, those employed in agriculture-related businesses and small town businesses dependent on the agricultural economy, and other rural residents.

Upon request from the caller, Farm Hotline staff mails a voucher with a list of mental health providers in their geographic area and contact information. Each voucher pays for one outpatient session. The caller has 30 days to redeem the voucher by receiving counseling from an approved provider. If more than one session is needed, up to 5 additional vouchers for therapist prescribed sessions can be obtained by calling the Hotline. (Some callers are provided more than 6 but additional sessions are provided free by the provider as the need in the rural/frontier areas is critical.) Mental health providers are reimbursed at the rate of \$50.00 for each 50-60 minute session provided and are required to submit a Demographic Data Form for each session provided under the program.

Mental health participation in the “Voucher Program” is voluntary. Currently, 179 licensed (a requirement) mental health providers in every part of the state have signed on to provide services under the Voucher Program. As of June 2002, 52 providers were currently active. Mental health providers include those in private practice, community health centers, and other social service agencies. A large number of providers have strong farm backgrounds and an understanding of rural culture.

The voucher program is managed on a per month allotment so the program will have funds for the entire year. Due to the prolonged rural farm crisis and the increasing demand for counseling services the Office of Mental Health, Substance Abuse, and Addiction Services doubled the funding to the Rural Mental Health Hotline and Crisis Counseling Program for FY 2002 to \$100,000 (\$80,000 for vouchers and \$20,000 for the hotline and will maintain this level of funding for FY 2003.) The program served 209 rural youth in FY03.

**GOAL #4:** To provide services to all children in non-Metropolitan areas.  
**POPULATION:** Children receiving services through the “Voucher Program” in non-Metro areas  
**OBJECTIVE:** The number of children in non Metropolitan areas receiving services will be maintained.  
**CRITERION:** Targeted Services to Rural and Homeless Populations  
**BRIEF NAME:** Non Metropolitan children  
**INDICATOR:** Number of children receiving “Voucher” services  
**MEASURE:** Count of Non-Metropolitan children receiving services  
**SOURCE OF INFORMATION:** Database for Rural Crisis Voucher Program

1. Performance Indicator	2. FY 2002 Actual	3. FY 2003 Actual	FY 2004 Objective	% Attain
Number of children in non-Metropolitan areas receiving Voucher services	278	209	209	

**Criterion 5: Management Systems**

- Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan
- Provides for training of providers of emergency health services regarding mental health
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved

**Current Mental Health and Substance Abuse (State & Federal Block Grant) Funding**

State mental health and Federal Block Grant funds are administered through the Department of Health and Human Services Office of Mental Health, Substance Abuse and Addiction Services and are used primarily to fund services for persons who are not Medicaid eligible or to fund services not covered by Medicaid. These services include the Professional Partner Program, outpatient treatment, school wraparound (formerly called therapeutic consultation), respite care, day treatment, and home-based services.

**Training of Providers of Emergency Health Services**

See the adult Criteria 5 for information regarding training of providers of emergency health services regarding mental health.

**Description of the manner in which the State intends to expend the grant**

The description of how the state intends to expend the Community Mental Health Block Grant for children and youth is contained in **Section 3 “Fiscal Planning Assumptions” for the details on children’s allocation for FY2004.**

**Innovative Services.** A number of innovative services have been funded through federal block grant funds. These include the Professional Partner Program, and middle intensity services like day treatment and school wraparound.

**GOAL:** At least maintain the Per Capita State Expenditures for Community Mental Health Services

**OBJECTIVE:** By June 30, 2004, there will be at least the same level of spending in per capita state expenditures for children’s community mental health services at \$8.82.

**POPULATION:** Total children’s population ages 0-17 years.

**Per Capita State Expenditures for Community Mental Health Services**

Numerator = Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = per Capita ...Total children’s population ages 0-17 years (450, 242)

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001 <<http://info.ned.org/stathand/bsect8.htm>>.

Performance Indicator: (1)	FY 2002 Actual (2)	FY2003 Actual (3)	FY2004 Estimated (4)	% ATTAIN (5)
Value:	\$8.43	\$8.60	\$8.49	
Numerator	\$3,793,391	\$3,872,010	\$3,820,804	
Denominator	450,242	450,242	450,242	

# Nebraska Mental Health Planning and Evaluation Council

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August 2003

Lou Ellen Rice  
Grants Manager  
SAMSHA Office of Program Services, Division of Grants Management  
Room 13-103, Parklawn Building  
5600 Fisher's Lane  
Rockville, MD 20857

Dear Ms. Rice:

August 8, 2003, the Nebraska Mental Health Planning and Evaluation Council reviewed the draft of the FY2004 Nebraska Block Grant application

Sincerely yours,

Constance H. Zimmer, Chair  
Nebraska Mental Health Planning and Evaluation Council

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